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Consultation on future health strategies for India.

REPORT

MINISTRY OF HEALTH & FAMILY WELFARE
(DEPARTMENT OF HEALTH)
GOVERNMENT OF INDIA

REPORT

CONSULTATION ON FUTURE HEALTH STRATEGIES FOR INDIA

GOA WORKSHOP
(IN COLLABORATION WITH
THE WORLD BANK)

NOVEMBER 12 - 14, 1996

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SUMMARY

OF

PROCEEDINGS

The Ministry of Health and Family Welfare, Government of India had organised a **Consultation on Future Health Strategies for India** in collaboration with the World Bank. The 3 day programme (from 12-14 November, 1996) held at Goa was attended by 48 delegates comprising 20 **representatives from various States** including Health Secretaries, Project Directors, Directors of Health Services, 9 Senior **Officers from the Union Ministry of Health and Family Welfare**, a team of 12 members from World Bank, representatives of **ODA (4), KfW(1), GTZ (1), WHO (1),** and a Professor from AIIMS. Representatives from other Ministries of the Central Government and the Department of Family Welfare who had been invited could not attend because of exigencies of work.

Welcoming the delegates, **Dr. K.K. Datta, Director, National Institute of Communicable Diseases, Delhi** highlighted some of the issues he felt merited serious consideration. **Mr. Richard Skolnik** of the **World Bank** outlined the objectives of the Consultation. He said the World Bank perceived India as a country of enormous importance which is poised to become an important economic tiger in the 21st century. He stressed the need for India to focus more attention on health and human capital development. He traced the long collaboration of the World Bank with India from 1945 onwards.

Mr. Skolnik hoped the Consultation would address the issues relating to **status and structure of the health systems** of India, its state of preparedness to meet the emerging health needs, the role of different sectors, the resources required, and the sources of funding for these activities. He pointed to various deficiencies in the current health system in USA such as high expenditure, poor returns, large number of people not covered, and gap between covered and not covered.

THE HEALTH SECTOR IN INDIA
-AN OVERVIEW OF SOME MAJOR CONCERNS

Mr. P.P. Chauhan, Secretary (Health), Government of India in his address elaborated on the increasing effort being made to see what can feasibly be achieved in the short medium and long term to contain diseases, promote health life styles and prevent illness episodes. There had been a **paradigm shift in the nineties.** Huge external aid had become available for important **disease control programmes** such Blindness, Leprosy and AIDS. Councils were being set up to co-ordinate **supply of blood and blood products** and phase out professional blood donation. The **Tuberculosis Control Project** planned to cover an estimated 35 million TB patients in a phased manner every year in 102 districts. There had been a resurgence of malaria with 2.2 to 2.8 million cases recorded every year. A **Malaria Control Programme** was being planned with World Bank assistance for the malaria endemic and tribal areas with provision to respond to special locational problems through new generation insecticides, bio-friendly measures and building a capacity through new strategies emphasising community participation, Management Information System, Human Resource Development and Information Education and Communication activities to prevent occurrence and better control of malaria in the long run.

Mr. Chauhan drew attention to the problems of

- Newly emerging diseases like dengue
- Increasing urbanisation, and its effects on pollution, solid and liquid waste disposal leading to several health hazards
- Management of hospital waste
- Intra-state and inter-state disparities in the provision of health services
- Shortage of medical and para-medical manpower in rural areas
- Need for capacity building in the areas of vaccine production, drug control and food safety

Mr Chauhan informed the delegates that an ambitious project had been taken up for upgrading the infrastructure in all district and subdivisional hospital in the States of Andhra Pradesh, Karnataka, West Bengal and Punjab with World Bank assistance of Rs. 2277 crores. He said that a **National Essential Drug** list had been adopted by the Government recently. A project for strengthening and upgrading drugs control organisation, the Medical Stores Organization, the National Food Control System and the vaccine production was under formulation for seeking World Bank assistance. The feasibility of widening the scope of **health insurance** in India was being explored. A **National Illness Assistance Fund** had been set up by the Government to enable poor people to get specialised treatment. He stressed the need for strengthening surveillance of diseases by building up epidemiological, entomological and bio-technological capacities.

CHALLENGES IN THE HEALTH SECTOR

Mrs. Shailaja Chandra, Addl. Secretary (Health), Govt. of India discussed the issues in health financing. She said that in the 8th Plan, of the total allocation in the health sector, central allocation was 24% and that by the States/UTs formed 76%. Among communicable diseases, the largest share (40.84%) was for Vector Borne Diseases followed by AIDS (26.76).

In terms of **disease burden** in 1990, communicable diseases accounted for 50.5% followed by Non-communicable diseases (40.4%) and Injuries (9.1%). The leading causes of death due to communicable Diseases in 1990 were acute diarrhoeal diseases (57.9%), acute respiratory illness (23%) and TB (19%). Mrs Chandra drew attention to the huge gap in health status within the states and between the states resulting in huge **disparity**. 29.9% of the population in India were still below the poverty line. As regards the suggestion to move from a population based approach to a disease-based approach, she was of the firm view that a population-based approach would be necessary for some more years.

Mrs. Chandra highlighted the need for building an **effective surveillance** system and for appointing a **District Health Manager** to co-ordinate health activities in health and health related sectors at the district level. She was in favour of giving **autonomy** to District Hospitals and Community Health Centres, to tertiary level hospitals in States and for central and state institutes. **Procurement and supply of drugs** could be moved to an autonomous corporate structure.

Among the major challenges she spoke about were:

1. Reducing disparity and inequity
2. Building surveillance systems which work
3. Making those responsible for health hazards responsive
4. Decentralisation in planning and implementation
5. Integrating programmes
6. Planning from below
7. Health financing through autonomy
8. Bringing Environment Health and Sanitation high or national agenda

Mrs Chandra also gave a broad overview of the priorities that had been drawn up by a group of four Ministries convened by the Ministry of Health and Family Welfare for improving **Environmental Health and Sanitation**. The **Healthy City concept** advocated by WHO was also mentioned by her, covering the trans Yamuna area of Delhi as a pilot effort.

HEALTH SYSTEM REFORMS IN DEVELOPING COUNTRIES

Dr. Richard Feachem reflected on the current global debate on health policy. He mentioned that world-wide, there had been a major shift from the agenda of child health, infection, maternal health and malnutrition to non-communicable diseases (NCD) and injuries. In India, it had been projected that between 1990 and 2020 communicable diseases as a proportion of a total burden of communicable disease (CD) would fall from 58.4 to 24.4% and

non-communicable diseases and injuries would rise to 56.5% and 19.1% respectively.

While in OECD countries, health expenditures accounted for 9% of the GDP, in India, the corresponding figure was only 6%. In established market economies, the total health expenditure per capita was US $ 1959; in India, it was only US $ 21. As countries get wealthier, they tend to spend a higher proportion of GDP on health. India was spending a far higher proportion of GDP on health than its income level would predict. In USA, 55% of health expenditure was in the private sector as against 78% in the case of India.

As regards **technology**, he was critical of the rise in hi-tech facilities with limited efficiencies in USA. Value for money varied enormously with Vitamin A supplementation costing a little over $ 1 per DALY saved, while for terminal care it is $ 10 million per DALY. Dr. Feachem felt that there was a need to identify avenues for getting more returns while spending less.

Tracing the evolution of health lending, he explained why the Bank was interested in investing in National Health policies. Dr. Feachem elaborated on the Human Capital equation, wherein a healthy population combined with education was a necessary basis for enlarging welfare, reducing poverty and sustainable growth.

While World Bank had financed health and welfare projects in 86 countries during 1986-96, India had been the largest recipient with $ 2,377 million. He also highlighted the role of private sector in India and the need for promoting professional self regulation.

The following needs were raised during the discussion that ensued:

- Professional education and education of people on proper use of drugs and getting value for money.
- Ensuring quality assurance of medical service and products

- Adequacy of health professionals as managers
- Developing and enforcing standards for controlling private sector
- Establishing more public health schools

Dr. Feachem responded that, for regulating the private sector, various countries had tried different approaches such as legal, managerial, user education, professional self regulation and financial incentives. Good quality leads to enhancement in efficiency. India should invest in manpower in public health and health economics. It was possible that, in future, intervention for NCD may be cheaper, and for CD it may become expensive.

HEALTH TRANSITIONS

Dr. Anthony Measham of the **World Bank** observed that life expectancy in India had increased from the low 40s in the 1950s to 62 in 1984. While more than 50% of the deaths currently were from the unfinished agenda, this was likely to decline to 22% by 2020, while NCDs would rise to 56.5%. He drew attention to the three **engines which drive health transitions**: an ageing population, specific risk factors, and access and use of preventive and curative health services. Tobacco use, he said, would account for 13% of deaths by 2020. There was a need to address the rise in NCDs through primary and secondary prevention, and investments in preventive and case management interventions of low cost and high effectiveness.

He identified the following areas as requiring **special priority attention**:

- **Tobacco Control**
- Low-cost and **widely accessible secondary treatment of common chronic diseases**
- Mounting a **Massive Health Information and health promotion campaign** regarding lifestyle, with particular emphasis on tobacco control and cardiovascular disease.

Under nutrition: 53% of under five children in India were moderately or severely malnourished. This had a huge impact on child mortality. Under five mortality of 123 consisted of 73 infant deaths and 50 deaths at age 1-4. Two thirds of infant mortality occurred in the neonatal period and at least 50% was related to low birth weight. Infant and child mortality in some urban slums was higher than rural areas. About 80% of women are anaemic; maternal mortality rate was high at 4.37 per thousand live births.

India's **sex ratio** of 927 was among the lowest in the World. Women under thirty had a lower life expectancy than men in India. Dr. Measham suggested four areas for priority action:

1. Female primary education
2. A Woman and Child First Policy in Health Services
3. Prevention of undernutrition
4. Nutrition interventions.

Commenting on the **division of responsibility** of nutrition and public sector delivery system among the different of the Government of India, Dr. Measham suggested **increasing convergence** of the ANM and Anganwadi worker with a joint training programme and combining of activities e.g. antenatal clinics at the village level. He recommended adoption of **locally appropriate packages** to meet the epidemiological and social diversity in India and a flexible system of training that allows different priorities to be emphasised in different areas.

NON COMMUNICABLE DISEASES

Dr. K. Srinath Reddy, Professor of Cardiology at the **All India Institute of Medical Sciences, New Delhi,** drew attention to the change in the rank order of DALYs projected for the year 2020 with Ischaemic Heart Disease, unipolar major depression, road traffic accidents and cardio-

vascular accidents occupying the highest ranks as compared to Lower Respiratory Infections, diarrhoeal diseases and perinatal conditions at present. It is estimated that cardio-vascular disease (CVD) accounted for 8-9 million deaths in developing countries with China and India alone accounting for 4.5 to 5 million deaths. He saw indications of a CVD epidemic emerging from the demographic change, lifestyle change and Barker Hypothesis. The cause specific mortality rate due to disease of the circulatory system in rural India has risen from 9.6% in 1983 to 12% in 1990.

While the rural population had higher smoking rates, other risk factors were higher in the urban population. He expected that there would be 54 million persons in the age group of 35 to 64 years with hypertension in 2000 AD. Dr. Reddy mentioned the social costs of high cost technological intervention required for diagnosis and care, non-availability of access and affordability and depletion of resources for the unfinished agenda would have catastrophic consequences when the social gradient reversed. He cited studies which reported a higher prevalence of CVD in low socio-economic status groups.

Tobacco related health conditions accounted for one million deaths annually 33% of Cancer, 25% of heart attacks and 15 million cases of CVD. Dr. Reddy discussed the various **strategies for tobacco control** including legislation, increasing taxes, ban on advertising warning on packages, community health education and Agro Industrial policies. He suggested the **judicious combination of lifestyle and pharmacologic approaches** for control of non-communicable diseases, especially hypertension.

Dr. Reddy elaborated on the various components of the **capacity building project for CVD control.** He stressed the need for a multi-sectoral approach for meeting the policy and implementation issues. For HFA renewal strategy, he emphasised importance of considering equity, inter-generational sustainability and gender sensitivity. He also presented **a model for CVD**

prevention in the community involving the district health professional school health and organised sectors

The following points emerged during the discussion:

- Paucity of reliable studies on tobacco
- Differing patterns of tobacco use
- Need for developing modules for training medical and para-medical personnel in NCD prevention and control.
- Education through mass media was more important than through health workers who were over burdened.
- Need for various states to enact legislation on the lines of the Delhi bill passed recently.
- Health transition - pace may vary from state to state in India. This needs to be studied.
- Need for identifying and using low-cost high yield technologies for diagnosis and management of NCDs.

INAUGURAL FUNCTION

The **Hon'ble Union Minister of State for Health and Family Welfare, Shri Saleem I Sherwani** inaugurated the Workshop by lighting the lamp along **with Dr. Wilfred Meskita, Hon'ble Minister for Sports and Youth Affairs** of the Government of Goa. Mr. Amarjit Singh welcomed the distinguished guests and appraised them of the progress in the deliberations.

In his **Presidential address, Dr. Wilfred Meskita** extended a healthy welcome to the delegates to Goa and hoped that the workshop would come forth with appropriate strategies to face and overcome new challenges as we stand on the threshold of the 21st century. He was proud of Goa's achievements in the field of health and family welfare. While prior to liberation, the focus was solely on the curative side, the post-liberation policies of the Government had given equal emphasis to the preventive aspects. The Maternal Mortality Rate was almost touching zero presently. There was one hospital per 10,000 population against the all India figure of 1

per 60,000. He hoped the Workshop would be the harbinger of new initiatives to improve the health of the people.

Mr. Sherwani, in his **inaugural address**, expressed the concern of the government of India with poverty reduction, equity of access to health facilities and securing a prominent place for health in the overall development framework. He underscored the need for addressing the issues relating to **better management, more efficient administration, greater accountability and improved quality and performance of services** in the health sector. He expressed concern at the **emergence and re-emergence of infectious diseases.** While elimination of polio, neonatal tetanus and leprosy were expected to be achieved in the near future, plague, malaria and kala-azar had staged a comeback.

Mr. Sherwani stressed the need for addressing the **environment issues**, **urban health,** and **problems of old age**. He pointed out that improving health status of a population that increased by 17 million annually posed a major challenge. He expressed satisfaction with the **rationalisation of service norms**, proper and adequate funding for PHCs, planning, surveillance and maintenance in the four states covered under the State Health Systems Development Project.

Stressing the pressing need **to strengthen public health capacities**, he called for **holistic view** on the gamut of issues like water supply, sanitation, healthy lifestyles and pollution. Hospitals needed to be more concerned with the health needs of the women and of the depressed and weaker classes of society. The success of the **State Health Systems Projects** would only be judged by the satisfaction that the poor express in rural areas, he said.

Mr. Sherwani also drew attention to the potential available in the **Indigenous Systems of Medicine** and the need to encourage the use of

locally available and safe, cost-effective therapy, which may provide solution to some of our intractable problems. He also underscored the need for quickly arresting the growth of the population through family welfare programmes.

Commenting on the **initiatives taken recently for regulating private sector** providers, he mentioned about the Consumer Protection Act, and the proposals for accreditation and creation of a Citizens Charter which are being seriously considered. He hoped the outcome of the Workshop would serve as a strong foundation for future developments.

REVIEW OF HEALTH SECTOR REFORMS IN SOME STATES

Mr. **Nagarjuna Rao, Project Manager** for **Andhra Pradesh** described the proposed **health** sector reforms in **Andhra Pradesh**. He said that a committee had been constituted by the State Government two months earlier to study the issue of Health Sector Reforms and to suggest changes for improving the efficiency of the hospitals and the credibility of government organisations in delivering health care. He highlighted the various problems at the primary level, such as large number of vacancies at Primary level and unwillingness of doctors to stay in rural areas. Incentives were being worked out, categorisation was being done at PHCs; and each doctor was being asked to work for at least 5 years in a category 'C 'centre.

Among the **major Problems** identified were poor administration, poor functioning of PHCs, sub-optimal utilisation of resources, and poor level of patient satisfaction. A variety of **solutions** had been proposed, which included:

- Divesting Medical Superintendents of all non-administrative duties and providing them training in hospital administration.
- Finalising medical code demarcating the duties of different staff

- Establishing Hospital Development Societies at all levels with adequate powers and autonomy. These would decide priorities for hospitals with non-salary portion.
- Providing greater role for local body institutions in administration
- Assigning selected NGOs to run PHCs in remote areas
- Introduction of referral protocol and system. This had been done in 2 districts and was being done in one more district.
- Clear demarcation of facilities to patients and provision of counselling services.

Mr. Pradeep Puri, Project Director from Karnataka then introduced the salient features of the State's proposal to develop a rational system of user charges, while providing a safety net for the poor.

Mr. Sherwani, Hon'ble MOS, who chaired the session, expressed the view that government hospitals should be upgraded so that people develop confidence in quality of services, and may then be willing to pay user charges.

Dr. Tawhid Nawaz from the **World Bank,** presenting an operational perspective, stressed the need for developing an action plan in several key areas in **Health Systems Research** for states that want to improve performance of their health care systems. There should be an agenda for setting the stage without escalating costs. He suggested analysis of **Health Care Financing** (HCF) issues such as health insurance and community financing, along with efficiency and effectiveness analysis of technical paradigm shifts related to specific health interventions. He made a plea for looking beyond the population based approach in devising a strategy

because of inherent inefficiencies, shortcomings in technical efficiency of programmes, and insufficiency of incentive for the workforce.

Dr. Nawaz suggested that effort should be made for reorienting the health care strategy towards addressing the epidemiological needs at the community level, rationalising service norms and updating technical paradigms. Incentives for staff needed to be enhanced along with provision of in-service training, and limited treatment of non-communicable diseases which would be cost effective. he was of the view that public-private partnership should be faster. Contracting out-of services requires higher management capability than running the service. The capacity for monitoring and regulation needed to be expanded.

The complex financing arrangements and administrative structure needed to be changed, and any inadequacy of the **Centre-State HCF mechanism** had to be rectified. The State Financing arrangements can be strengthened by reviewing fiscal structures and developing budgeting and financial tools and through provision of supplementary financing. The allocation for the health sector and especially for drugs was low due to deteriorating overall fiscal situation in many States. The expenditure on health and family welfare was 1.4% of GDP in Karnataka, 1.2% in West Bengal and 1.03% in Andhra Pradesh.

He suggested that the State expenditure on health should be enhanced and prioritised. This could be achieved by improving overall State financing, increasing allocation for health within the overall budge, re-evaluating priorities within the health budget or increasing allocation for non-salary recurrent costs.

Dr. Nawaz discussed various **alternative methods of Health Care Financing**. He listed some possible problems that could be encountered as the lack of institutional framework for receiving user-chargers, minimal level of cost recovery, inadequate targeting mechanism to exempt the poor, and lack of power to retain funds at the point of collection. Also the definition of poverty line is difficult. he suggested the need for the Central and State Governments to strengthen their analytic capacity for health care planning. Cost-effective analysis should help fine tune policy planning. He suggested strengthening of public-sector management and increased emphasis on de-centralisation. Dr. Nawaz also emphasised the need for proper medical waste disposal.

During discussion, **Mr. Skolnik** suggested that India should consider stopping subsidies for water and power for rich people. **Mr. Sherwani, Hon'ble Union Minister of State for Health & Family Welfare** said that the Government of India is taking a fresh look at the health sector for more allocation in the Ninth Plan. While the Government of India was confident that **the State Health System Project** could be carried out, this might

have to be done in a phased manner in larger States like Uttar Pradesh. He also informed that private hospitals providing free beds should have a separate free wing so that monitoring is easy.

Mr. Cowlagi, Additional Chief Secretary (Health), Gujarat informed that in-house hospitals provide care to the people in their neighbourhood, and, in the border areas, the army caters to the needs of the local civilian population. **Mr. G.P.S. Shahi, Principal Secretary (Health), Punjab** felt that the user charges collected by an establishment should be utilised at the same spot. He also said that Punjab has given incentives for doctors to work in rural areas. By floating open tenders, not merely was there greater transparency but also allocative efficiency in procurement of drugs. The prices were found to fall by 75% with I.V. saline coming down from Rs 22 per bottle to Rs 6. The computerisation of drug stock helped speedy despatch on indent.

Mr. Vijay Chandran, Secretary (Health) from Kerala, sought clarification from World Bank on repayment after moratorium period. He said Kerala has hospital advisory committees. All the charges are used for hospital development activities. He however felt that contracting out of service requires less management expertise than for running the service. **Ms M. Gupta, Secretary (Health & Family Welfare) from Orissa** thought that user-charges may give rise to unnecessary interventions like performing Caesarean section in place of normal delivery. She mentioned that the Government of Orissa has successfully contracted out clinic services to a private hospital in Bhubaneshwar and the public response has been positive.

Dr. K.K. Dutta felt that community medicine specialists should be posted as District Health Officers. He suggested that the National Health Policy of 1983 should be reviewed and revised in the light of the changing paradigms.

Mr. Mehrotra, Principal Secretary (Health), Madhya Pradesh wondered whether the allocation in PHCs for salary (Rs 450,000) and that for medicines (Rs 10,000) were in the right proportion. He wanted the investment decisions to be rational. He also said that in Madhya Pradesh there was no regular school for health technicians training and no State institute of Communicable Diseases.

Dr. Nawaz informed that, for the State Health Systems project, 70% of loan is at 13.5% interest and the rest 30% is interest free, thus giving an overall interest of 8%. This has to be considered in the background of the inflation rate of around 6.5%.

ISSUES AND OPTIONS IN HEALTH PLANNING

Prof. Dean Jamison, World Bank Consultant and Director of Pacific Rim Studies at the University of California at Los Angeles explained the need for measuring performance of the system as a design for health care financing. The outcomes have to be evaluated in terms of health improvements effected and societal resources consumed to determine the desired trade off. He reported on India's progress in income and education. As regards health, he said that the under-5 mortality rate was 14% worse than expected in 1960, in 1990 the figure was 17%. The fertility rate was 1% higher than expected in 1960 and 20% higher in 1990.

He discussed the various **delivery options**. The first generation which characterise 3/4th of the Indian system lack risk-sharing mechanisms and demand for more efficient coverage of risk. The second generation of systems embody substantial pre-payment of clinical expenses to pool risks. The third generation which is combative, competitive and comprehensive comprises competing systems (with either vertical or virtual integration), and categorical systems.

Discussing the various options for finance, he said that a substantial public sector role in financing health systems creates an incentive environment for cost containment and for better intervention selection resulting in improved performance. He said that India has to decide whether to move in the direction taken by US or towards other OECD countries.

He also discussed the various alternatives for future HCF. He mentioned that the other objectives of fiscal policy were to reduce deficit by 6% of GDP, to increase public expenditure on health by 2.5% of GDP and to maintain the State sector at around 30% of GDP. He suggested reform and modernising of State expenditures and revenues. He said that although the European systems spent 5 to 6% of GDP less on health than what the USA did, still the former produced better health outcomes than the latter.

The following points emerged during discussion:

- Inequity exists among Indian States.
- Realistic phasing is required.
- HCF and planning should be based on needs and not on GDP. Health care financing allocation should be by a democratic process.
- Potential in community health financing / village health cooperatives should be explored.
- Consideration should be given for equity implications of options for the future. Govt. finance is more equitable than social insurance. Activity should be expanded sector by sector using micro-economic approach.
- Major readjustment may be required in the compensation.

Dr. Feachem clarified that Kerala reports higher morbidity because educated and healthier people report more illness. Public financing of health care either through general taxes or social insurance mandated finance does not imply government provision of health care.

GROUP DISCUSSIONS

Two groups were then formed to discuss the issues, which had been brought up. The first group moderated by **Mr. V.R.S. Cowlagi**, Addl. Chief Secretary, Government of Gujarat focussed on the devolution of responsibility between State, District and Panchayat Administration in the Health Sector. The second group, moderated by **Dr. Salim Habayeb**, Senior Public Health Specialist, World Bank deliberated on the Private & Public Roles in Health Financing and Delivery

The reports of the two groups were then presented and discussed at the Consultation. **Mr Cowlagi**, in his report, differentiated decentralisation from other related concepts such as deconcentration, delegation, devolution and privatisation. The Group had also identified various obstacles to decentralisation, such as fear of the unions, and inability to retain use charges. The solutions suggested included empowerment through training of elected representatives, Lok Adalats and Mahila Sammelans, raising of resources by giving away sources of tax to the local bodies, provision of incentive outlays and enabling flow of donations through institutional or statutory changes, and identifying a neutral umpire to enable the local bodies to get their due from the state government.

The Group also identified certain problems which could arise with reckless decentralisation such as poor technical support, diffused accountability and administrative laxity. It emphasised the need for open debates and democratic decision making, and for empowering representatives of women, SC/ST groups. It also suggested that technical, financial and social audit should be conducted at regular intervals to keep the local bodies on the right track.

The report of Group II was presented by **Dr K. Srinath Reddy**. The group recognised the important role played by the private sector in health care delivery in India. The Group suggested the need for studies on varied composition and growth patterns of the private sector and to obtain disaggregated estimates for decentralised health planning. The Group also drew attention to the increasingly larger role of the private sector and its participation in primary and secondary health care both directly and also through contracted services. It suggested a study of currently available experience on the private sector's ability to deliver contracted services efficiently.

The necessity of regulation and monitoring of the performance of the private sector was also stressed. Establishment of an independent competent and adequately empowered authority was suggested for this purpose. Programmes for skill upgradation of the health care providers and periodic evaluation and recertification procedures also needed to be studied and implemented. The Group also suggested that while incentives like subsidised land were provided to the private sector, there should be a reciprocal commitment to utilising a portion of the health care resources to serve the poor. A study of the experience of the bulk purchasers of private sector services was also proposed.

As regards the public sector, the Group stressed the need to redefine its role in the context of services directly provided ad the facilitation of the private and non-government sectors. It envisaged the public sector as playing an increasingly promotional role rather than a providing role. Some of the services, that the public sector provided, should be contracted out. Greater institutional autonomy should be provided to governmental institutions. Partnerships should be encouraged through joint sector ventures or through contracting services to the private sector and NGOs. Monitoring and regulation

of standards of health care in the government sector was also essential. The nature and effects of performance enhancing incentives needed to be studied.

The Group also recommended study of the contributory role of alternate systems of medicine to private sector health needs. The group emphasised the need to strengthen district health management systems and for studying the various innovative reforms introduced in various states. It suggested the publication of a regular newsletter with such case studies to serve as a continuing forum for discussion health policy issues.

INDIA HEALTH, NUTRITION AND POPULATION PORTFOLIO

Dr Richard Skolnik informed the delegates that there had been a dramatic increase in the portfolio of Health Nutrition and Population since 1988. He said that, presently, there were 13 projects under this head valued at over US$ 1.6 million or a tenth of the total India portfolio. The Health portion was the youngest and fastest growing portfolio with 5 projects, valued at US$ 768.9 million, aimed at state health system reform and disease control, prevention and elimination. Population portfolio came next; with 5 projects, valued at US$ 518.9 million, it aimed at promoting family planning, child survival / safe motherhood and reproductive and child health. The Nutrition portfolio with 3 projects valued at US$ 335.9 million was focussed on integrated child development, nutrition and woman and child development.

Geographically, the Portfolio of HNP had a wide scope with centrally sponsored / national projects such as AIDS prevention, leprosy elimination, child survival and safe motherhood, centrally sponsored / multi-state projects, and state sector projects with one or more states, such as State health Systems I and II. Dr Skolnik found that most projects were performing satisfactorily and were likely to meet their objectives; he was concerned at the delay, and the fact that

some states were performing less well on HNP projects than other states. The performance was also uneven in most projects

There had been a steady increase in disbursements over the past four years, from US$ 49.6 million in financial year 1993 to US$ 147.6 million in financial year 1996. The disbursement ratio had increased from 6.6% to 13.7% over the same period. Population subsector had recorded the fastest disbursing followed by nutrition and health.

Dr Skolnik identified some key project implementation issues, on which he wanted the various project managers to focus attention on:

- Insufficient preparation of projects
- Failure to appoint management staff in a timely manner
- Rapid turnover of the staff
- Poor flow of funds
- Poor quality of construction
- Inefficiency of procurement system
- Inadequacy of attention for "software"
- Inadequacy of project supervision
- Slow start and inordinate delays in project.

Certain suggestions were given by Dr Skolnik for improving project implementation. These included:

1. Approval should be accorded for projects only after they had completed the first round of tendering, appointed management staff, have a budget and accounting system and are ready to initiate works.

2. Measures should be taken for reducing staff turnover.

3. Problems in flow of funds and staffing should be treated as immediate causes for "alarm"

4 Project managers should work with beneficiaries in design, and with private consultants / architects on construction and construction supervision.

5 Competent procurement specialists should be involved in procurement work including establishing of service standards and their maintenance

6.The central and state supervision should be strengthened.

7.More third party supervision should be carried out along with periodical external reviews focussed on software.

8.It should be ensured, using IEC, that project staff see that paradigm shifts are at the core of each project

VALEDICTORY SESSION

Dr. Feachem gave an overview of the views expressed in the Consultation. He suggested that the framework for guiding the relationship between World Bank and India over the next few years should be based on the following 4 pillars:

1. **Unfinished agenda** of child health, maternal health reproductive health, malnutrition, fertility reduction and control of communicable diseases.
2. **HIV/AIDS** - India faces the potential threat of a devastating epidemic and should try to stabilise the prevalence rates of HIV infection in general population at 2%.
3. **Non-communicable diseases and tobacco** - is the single largest preventable risk factor for health that needs to be tackled as also the rising tide of health problems from other non-communicable diseases.
4. **Training and capacity building** through a macro-policy framework, quality assurance technology and fundamental changes in structure.

He proposed arranging study tours abroad for people from India, bringing appropriate experts to visit India, and arranging other appropriate forms of training. The particular focus would be on building capacity in health policy, health economics and health finance. He suggested that the increased capability from training and institution building would help promote an on-going and vigorous informed debate. He was hopeful that useful lessons would emerge from the current and diverse experience of India.

Dr Feachem advised India to commission specific pieces of analysis like study of public subsidies to private sector in areas such as medical equipment, land or manpower training, private services in public facilities by public salaried doctors. He also suggested that equity dimension should be studied. The focus should be on private health care sector in urban areas. He assured the Govt. of India of the World Bank's willingness to cooperate with it.

Mrs. Shailaja Chandra, Additional Secretary (Health), Government of India gave her comments on the outcomes of the workshops and people's reaction. She said that the Hon'ble Minister of State had already called for review and reorientation of the National Health Policy of 1983. She said that the renewal paradigm referred to by the WHO Health For All policy needs to be debated by people. She said that autonomy / decentralisation of hospitals at district level and above would greatly help improve the functioning of the health systems. She said that there was a need to study the experience of other countries in the area of cost recovery and utilisation.

Mrs. Chandra said that the Government had a responsibility for regulating health care. She called for greater acountability of the delivery systems and ensuring more specificity. She stressed the need for developing a national level surveillance system. The Tobacco Control Programme to be developed should use innovative approaches for drawing in active involvement

of the people other than from health sector. She hoped that there would be increased active interaction with the World Bank.

Mrs Chandra thanked all the delegates for making the Consultation very purposeful and productive and the various international organisations for their active participation. She expected that the outcome of the deliberations would guide the development of future health care strategies both for the centre and for the states.

GROUP

REPORTS

GROUP-1
Devolution of responsibility between State, District and Panchayat Administration in the Health Sector

Moderator: Mr V.R.S. Cowlagi,
Addl. Chief Secretary, Government of Gujarat.

1. Mr. Richard Skolnik
2. Mr. Badrud Duza
3. Ms. Shreelata Rao Seshadri
4. Mr. Dean Jamison
5. Ms. Maria Clark
6. Mr. Raj Kumar
7. Mr. G.P. Sahi
8. Mr. D.S. Bains
9. Mrs. Leena Chakraborty
10. Mr. Alok Mukherjee
11. Mr. R. Poornalingam
12. Ms. Meena Gupta
13. Mr. R. Tiwari
14. Dr. Subhash Salunke
15. Dr. A.R. Basumatary
16. Dr. B.N.S. Walia
17. Dr. V.P. Bansal
18. Dr. Michael T. Siegert
20. Ms. Bindu S. Varghese
21. Mr. Andrew Cassels
22. Mr. Amarjit Singh
23. Mr. John Hoy.

The Group at the outset differentiated decentralisation for deconcentration, delegation, devolution and privatisation.

The following obstacles to decentralisation were identified;

1. Unions fear that the staff may be averse to closer scrutiny by the local elected representatives.

2. Only end up using funds voted by the assembly, unless powers for raising resources are also delegated, and additional sources of funding are identified.
3. Inability to retain user charges, due to the constitutional provisions and the objections of the Accountant General. A way out has to be found as has been done in the case of state level institutions in Gujarat for treatment of Cancer, Kidney and Heart diseases.

Empowering:

Training elected Representatives. For this purpose training centres for elected representatives are required. On-the- job knowledge would also be useful.

Lok Adalats help People to sort out their disputes on their own with active assistance from the judiciary thereby avoiding the lengthy and costly court procedures.

Mahila sammelans are a good way for creating awareness amongst women about their rights and providing them with a forum for fighting for them.

Raising Resources

Power of collection and use of taxes, like Land Revenue and Education Tax should given to the local bodies. Other sources of taxation like Entertainment tax could also be shared.

Incentive outlays could also be provided to reward tax effort. In states, matching grant is provided to the local body in proportion to the additional resources generated by the local body.

Necessary institutional and statutory changes may have to be carried out to enable flow of donations.

Neutral umpire

Need for a neutral umpire like the State Finance Commission, Gujarat Municipal Finance Board, to enable the local bodies to get their due from, the state Government.

Problems of Reckless Decentralisation

1. Tendency to filing money at problems, without any technical and institutional support.
2. Poor technical support, which likely to affect performance.
3. Administrative laxity if institutions are not created properly; adequate powers not delegated and staff not properly trained.
4. Accountability may be diffused. Cars and status symbols may become more important and not essentials like bleaching powder.
5. Takes longer to exchange perceptions. Communication may not be proper due to longer channels.
6. Old ties and vested interests may sabotage the process of decentralisation.
7. Powerful may grab all. As such adequate safeguards need to be built for the weak and the poor.

Shared Discussions

1. Village amenities survey; right access to information would improve decision making.
2. Need for open debate and democratic decision making.
3. Need for empowering representatives of women SC/ST groups to enable them to stand for their rights.
4. Training would be crucial to make decentralisation successful.

Be watchful

Technical financial and social audit at regular intervals to keep the local body on the right track. Professional organisations could be used o lay down standards.

GROUP II - Private/Public Roles in Health Financing and Delivery; Moderated by Dr. Salim Habayeb, Senior Public Health Specialist, World Bank.

1. Smt. Shailaja Chandra
2. Mr. Richard Feachem
3. Mr. Keith Hinchliffe
4. Mr. Anthony Measham
5. Mr. Tawhid Nawaz
6. Mr. Prabhat Jha
7. Mr. M Nagarjuna
8. Mr. Pradeep Puri
9. Dr. K.B. Makapur
10. Mr. J.P. Negi
11. Mr. R.N. Mahanta
12. Mr. P.K. Mehrotra
13. Mr. Lov Verma
14. Mr. S.P. Goud
15. Dr. S. Venkatesh
16. Dr. K.K. Dutta
17. Dr. K. Srinath Reddy
18. Dr. Rita Thapa
19. Mr. Bob Grose
20. Ms. Julia Cleaves Mosse
21. Smt. Renu Sahni Dhar
22. Mr. V. Vijayachandran

REPORT OF GROUP II By Dr. K. Srinath Reddy

The Group discussed the individual and interactive roles which the health care delivery services in the public, private and non-governmental sectors need to play in the integrated health care system, in response to the present and projected health scenarios of India.

THE PRIVATE SECTOR

The group recognised that the private sector is a large contributor to health care delivery in India. Though national average estimates for the private sector contribution to health care expenditure is 78% of the total, regional

profiles may vary across India. These regional dimensions would need further study for obtaining disaggregated estimates for decentralised health planning.

The private sector has a complex structure with both formal and non-formal components. Its varied composition and growth patterns would need systematic study.

The private sector is likely to play an increasingly larger role in the delivery of health care in the future. Apart from becoming the principal contributor to tertiary care, it is also likely to increase its participation in primary and secondary health care both directly and also through contracted services from the public sector.

In view of this likely future role, a critical appraisal of the private sector's ability to efficiently deliver contracted services is required through a study of currently available experience.

The important role which the private sector has in the health care system necessitates regulation and monitoring of its performance both because of (a) costs and (b) quality of services provided. These should be implemented in a way that enhances rather than curtails the efficiency of the private sector. Since governmental regulation and self-regulation have not proved successful in ensuring these objectives, an independent, competent and adequately empowered authority may need to be established for performing these regulatory and monitoring functions objectively and efficiently.

Health care delivery will be inefficient if the knowledge and skills of the providers are not continually upgraded. Feasible and cost-effective programmes for skills upgradation of the health care provides and periodic evaluation and recertification procedures of the providers require concerted study and implementation.

Agencies involved in the accreditation of private health care institutions must ensure that clearly defined standards and performance criteria are strictly adhered to; the obligatory duties that must be performed by such institutions, such as provision of emergency services and reporting of notifiable diseases, must be clearly defined and scrupulous compliance ensured.

The incentives which are provided to the private sector have often not served the intended purpose of providing benefits to the poorer sectors. Cash subsidies through institutional financing and government bank guarantees have been considered commercially non-viable and customs duty relaxation has been frequently misused. The allocation of subsidised land for construction has been an attractive incentive. However, the reciprocal commitment to utilise a defined proportion of health care resources for serving the poor is seldom honoured.

Therefore, the incentives may sometimes perversely serve to abet a private sector enterprise which is inefficiently utilising resources with respect to India's health care needs. The performance of the private sector with respect to the utilisation of incentives, the social spectrum of the beneficiaries of its services and its ability to perform contracted services needs in-depth study. The experience of bulk purchasers of private sector services (like large employers from the industry) is likely to be instructive and merits study and documentation.

PUBLIC SECTOR

The group affirmed that the public sector would continue to have a pivotal position in the health care system. It would, however, need to redefine its role in the context of services directly provided and the facilitation of the private and non-government sectors enabling them to play a more meaningful role.

The group envisaged the public sector increasingly performing the role of a promoter rather provider of health care services. It would need to contract out some of the services presently provided by it to the private and non-governmental sectors, with adequate monitoring to ensure that socially desirable goals are being cost-effectively served.

Examples of successful contracted services cited were of the primary health care centres in remote tribal areas of Madhya Pradesh now being run by the Ramakrishna Mission and a Trust Hospital at Itarsi. These need to be studied and documented so that replication is possible where feasible.

The need for providing greater institutional autonomy to governmental institutions of health care to enhance their efficiency and improve their performance was stressed by the group. The example of the Mental Hospital at Shahdra, Delhi was cited as a case where greater autonomy empowered the institution to raise additional financial resources to supplement government allocations and also provided greater flexibility in contracting out a part of the services.

The public sector's role as a facilitator enabling the private and non-governmental sectors to play an effective role in health care delivery requires the removal of bottlenecks which prevent these sectors from accessing existing health care resources. This is especially there for the non-governmental organisations. Simultaneously, monitoring systems must be improved to ensure efficient utilisation of these resources by their recipients. These areas need to be studied.

The role of the public sector in promoting partnerships through joint-sector ventures or through contracting services to the private sector and NGOs

needs to be made more effective through innovative reforms like a single win clearance facility.

The group stressed that monitoring and regulation of the standard health care in the government sector was also essential, analogous to th needs in the private sector. It felt that the independent authority suggested the private sectors performance regulation would also be appropriate performing this function for the government sector.

Skills upgradation of government sector health care providers was a recognized as an essential need. The mechanisms for ensuring and evaluat reforms aimed at this objective need to be studied.

The role of performance enhancing incentives in the government sec was also discussed. The example of special non-practicing allowance for doct serving in the remote areas of Himachal Pradesh was cited. The study of nature and effects of such incentives was recommended.

NGOs - ALTERNATE SYSTEMS

The growing role of NGOs participants in health care delivery w recognised. Their ability to provide health services as well as effectiv contribute to health education needs to be studies. Such services could contracted out to NGOs and the results evaluated.

The contributory role of alternate systems of medicine to private sec health care needs to be evaluated. This is feasible in states like Kerala whe these systems are playing a large role in health care delivery.

GENERAL

District Health Management needs to be strengthened to ensure bett allocation and utilisation of financial as well as human resources. Such syster need to be modelled and evaluated. Since several innovative reforms have be carried out in several parts of India and have fielded positive or negati outcomes worthy of critical study by health policy makers throughout the countr a NEWS LETTER must be initiated by the Ministry of Health, Governme of India. This Newsletter which described such case studies and also serves a a discussion forum on policy issues would advance the pace and process health care reforms in India.

ANNEXURES

PROGRAMME

November, 12, 1996

11.00 am -12.00 Noon	Opening Ceremony Welcome address by Dr. K.K. Dutta, Director, NICD Objectives of the workshop by Mr. Richard Skolnik, Chief, Population and Health, South Asia Country Department II, World Bank. The Health Sector in India. An overview of some major concerns by Shri P.P. Chauhan, Secretary (Health)
12.30 - 1.00 P.M.	Challenges in the Health Sector Speaker, Mrs. Shailaja Chandra, Additional Secretary, MOHFW
1.00 p. 2.00 pm	Lunch

SESSION 1-CHALLENGES AND OPPORTUNITIES IN HEALTH
CHAIRED BY MR. P.P. CHAUHAN, HEALTH SECRETARY, MOHFW, GOI

2.00 pm - 2.40 pm	Health Systems Reform - The Global Perspective; Implications for India. Speaker: Dr. Richard Feachem, Senior Adviser, World Bank
2.40 pm - 3.15 pm	discussion
3.30 pm - 4.30 pm	Health Transition; the Unfinished Agenda and the New Agenda of non-communicable Diseases and Injuries; Speakers; Dr. Anthony Measham, World Bank, and Dr. Srinath Reddy; AIIMS
4.30 pm - 5.30 pm	Discussion

November 13, 1996

SESSION II - STATE HEALTH SYSTEMS DEVELOPMENT chaired by Mr. GPS Sahi, Principal Secretary, Health, Government of Punjab.

9.30 am - 10.00 am	State Level Health Sector Reform in Andhra Pradesh Speaker; Mr. M. Nagarjune, Project Director, Andhra Pradesh Health Systems Development Project.

FORMAL INAUGURATION OF THE WORKSHOP

10.00 10.30 pm	Formal address by the Hon'ble Minister for Revenue and Sports, Govt. of Goa, Dr. Wilfred Meskita.
	Formal inauguration of the Workshop and address by Hon'ble Union Minister of State for Health & F.W., Shri Salim Iqbal Shervani.
	SESSION II Continued
10.45 am -11.15 am	State Level Health Sector Reform in Karnataka Speaker: Mr. Pradeep Puri, Project Director, of Karnataka State Health Systems Development Project, Bangalore.
11.14 am - 12.00 noon	A comparative Review of Health Sector Reform in Four States; An operational Perspective Speaker: Mr. T. Nawaz, Senior Economist, World Bank.
12.00 Noon 1.00 p.m.	Discussion

SESSION III-SPECIAL TOPICS chaired by Dr. R. Feachem, Senior Adviser, World Bank

2.00 pm - 2.30 pm	Issues and option in Health Planning Speaker: Dr. Dean Jamison, World Bank
2.30 pm - 3.00 pm	Discussion
3.00 pm- 3.15 p.m.	Tea break
3.15 p.m.	Break out Groups

	1. Devolution of responsibility between State District and Panchayat Administration in the Health Sector: Moderated by Principal Secretary, Health; Government of Gujarat, Shri V.R.S. Cowlagi
	2. Private/Public Roles in Health Financing and Deliver; Moderated by Dr. Salim Habayeb, Senior Public Health Specialist, World Bank.
4.30 pm	Report of the Groups and Discussions
November 14, 1996	SESSION IV - WRAP-UP
9.00 am - 10.30 am	State Level Implementational Issues by Mr. Richard Skolnik, World Bank
10.30 am - 10.45	Tea break
10.45 am - 11.30 am	Wrap up by Smt. Shailaja Chandra, Addl. Secretary (Health), Government of India.

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8. Ms. Shrilata Rao Seshadri
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10. Mr. Keith Hinchliffe
11. Dr. Prabhat Jha
12. Dr. Raj Kumar

INAUGURAL ADDRESS

SHRI SALEEM I. SHERVANI,
UNION MINISTER OF STATE
(INDEPENDENT CHARGE)
HEALTH & FAMILY WELFARE

Union Health Secretary, Mr. Chauhan; Mr. Richard Skolnik and other experts from the World Bank, KfW, and ODA, Health Secretaries and friends,

I am very pleased to be present here today to participate in this three day Workshop on the "Strategic Directions for the Health Sector in India". I had planned to be here yesterday itself, but some other pressing engagements enabled me to join you only today. I consider this an important Workshop and I am sure the deliberations here would contribute in a significant manner in bringing together new ideas and concepts for improving the health care delivery system in India.

In accordance with the mandate of my Government set out in the Common Minimum Needs Programmes, I am concerned with poverty reduction, equity of access to health facilities and securing a prominent place for health in the overall developmental framework. At the ground level a number of key issues need to be addressed; better management, more efficient administration, greater accountability and improved quality and performance of services in the health sector. Through the combined experience of all those present here including experts with wide international experience I am hopeful that we can develop strategies to be able to use resources in the best possible way.

During the past decade and particularly in the last 3-4 years we have seen the emergence and the re-emergence of infectious diseases. We have been successful in battling against a number of diseases in the past. Smallpox is a shining example of the will and the ability to control and eradicate the

disease. To this will soon be added the elimination of Polio, Guineaworm, Tetanus in the new-born and that formidable disease, Leprosy. Despite the successes, experts tell us that almost 30 new diseases have appeared on our planet in the last 20 years and the diseases that we had conquered or nearly conquered like Plague, Malaria, and Kala-azar have now staged a come back. Diseases which were eradicated from time to time have now assumed a more virulent characteristic particularly Dengue and Cholera.

Some of the most important factors which have influenced this phenomenon have been poor living conditions which in many areas have worsened for certain sections of the community, despite overall economic prosperity. Under the overall umbrella of development, dams and irrigation projects will be established and will have to expand. These are absolutely vital for agriculture and have led to great prosperity. But they have also created ecological conditions responsible for harbouring and promoting vector borne diseases. Industrialisation and energy pollutants have led to environmental degradation. Changes in the land use patterns and encroachments into forest areas have exposed the human population to infections which they did not encounter previously. Unplanned urbanisation and excessive population growth have created conditions for entry of infectious diseases in congested squatter settlements. Urban health has become a matter of overwhelming urgency. Changes in human lifestyles and behaviour including sexual behaviour and food habits have also opened up new avenues for the spread of infectious diseases.

In addition, as we add more old people to our population

we have to provide for problems of cardiovascular diseases, cancer, diabetes and cataract blindness while Malaria, Kala-azar, T.B. and now Dengue are still not over. Improving the health status of people, and meeting the health needs of a population that is increasing by 17 million annually presents a major challenge for India."

I have gone through the experience of Andhra Pradesh, Punjab, Karnataka and West Bengal, with great interest. Their projects have provided an opportunity to look at the health sector strategies afresh. I am glad that the rationalisation of service norms, proper and adequate funding for PHCs, CHCs, planning, surveillance and maintenance have all been given a thought.

Our biggest areas of concern today is the improvement of surveillance and dovetailing efforts in improving the quality of life of people. There is a pressing need to strengthen, public health capacities which really means looking at the whole gamut of issues like water supply, sanitation, healthy life styles and pollution in a holistic manner. All the arms of the Government and non-Government sector have to work in tandem to generate community awareness of environmental health and promote participation of people themselves in protecting their town families and neighbourhoods. There is a limit to what Governments can do. The recent outbreak of Dengue has been pointer for us. One of the most major causes was the presence of stagnant wanter in the people's coolers, overhead tanks and lack of basic precautions against the spread of the vector. This is where health education and public awareness is most crucial. We need to give an impetus

by involving the best communication and media experts to give messages to the public on what they can do for themselves to maintain good health. There is an immense scope for increasing NGO involvement in this area. The public has to be made responsible for its own good health and there must be an understanding of what is a householder responsibility to be differentiated from a public responsibility.

In the last few years a number of projects have been taken up with World Bank Assistance for control of Population growth, AIDS, Leprosy and Blindness; projects for control of malaria, TB and a project for Capacity building to strengthen inter-alia, Drug Control Organisation, Medical Stores set up and Prevention of Food Adulteration Administration is in the pipeline; in addition an ambitious project has been undertaken in four states of the country to upgrade the health infrastructure at the district and the sub district level to improve the health condition of the people particularly in the rural areas. Many evaluations have revealed that our hospitals have to be more concerned about womens' needs and those of the depressed and weaker classes of the society. I am pleased to note that certain special interventions for the weaker sections have found a place in these state projects. The project signifies a renewed emphasis on quality of health care services and provides a unique opportunity to the project states to fully realise the objectives of the project for the benefit of the poor in these states. However, the success of the state health systems Project would only be judged by the satisfaction expressed by the poor in the rural areas, whether the disadvantaged feel a difference in approach. We would be happy

to promote the expansion of the project in the deserving areas of other states to reduce intra-state disparities. It is heartening to note that the World Bank has also agreed to approach in this regard. I hope in the days to come there will be more and more missions from the World Bank, and more such workshops so that there are more funds for the health sector, in India.

At the same time the escalating costs of health care and the non-availability of drugs to combat some disease should also make us turn to the untapped wealth of traditional medicine. Fortunately in India we have a long tradition of Ayurveda, Siddha, Unani and Homoeopathy based on herbal medicines and drugless therapies of yoga and nature cure. India has rich resources of trained traditional medical practitioners in these systems of medicine and also quality standardised herbal remedies. Therefore to encourage the use of locally available safe and cost effective therapy we need to exploit this resource fully and in the process be rewarded by solutions to some of our intractable health problems.

In fact no amount of resources external or internal would suffice to meet the challenges before us, unless we succeed in quickly arresting the growth of our population. The rate at which our population is growing eats away the entire fruits of our developmental efforts. Therefore in order to bring about a meaningful and sustained improvement in the quality of life of our people, it is necessary to put an immediate brake on the ever increasing rate of growth of our population and thereby break the nexus between our population and poverty. We have assigned the highest priority to our family

welfare programmes in our current plan and expect results to be seen in the foreseeable future.

Today the need of the hour is to keep up efforts consistently to control and eliminate the communicable diseases. There has to be no room for complacency, and there should be no reason for despondency as the curable and preventable diseases of the poor may aggravate. There has to be a three pronged strategy first to foster an economic environment that enables people to improve their own health; secondly to reallocate government investments from specialised care in tertiary health care facilities to programmes of primary health care that would help the poor most, thirdly to facilitate and properly relate private sector involvement in health care.

Government sector alone can not however, take care of the entire health care needs of our large growing population. For the country as a whole private household and non-household expenditure has been reported to be about 2/3rd of the total health expenditure. As such the private health facilities are an important national health resources and it is important that these resources are used optimally. I have been very concerned about building capacity to undertake meaningful monitoring and control strategies so that private investments are directed to the establishment of right type of technologies to meet the objective of providing good quality health care at the least possible cost. In the case of over dependence on the private sector there is a real possibility of private facilities including over supply of services and leading to harmful cost cutting. On the other extreme there is a danger of development

of a two tier system of medical care, expensive and high quality services for the rich, and lower grade services for the poor. It is for this reason the consumer groups have been asking for greater accountability of the private sector to ensure that the health care does not become a tool for exploitation of the vulnerable sections of the population.

Keeping in view the urgent need to regulate the private sector health care providers we have taken the following steps to safeguard the interests of the consumers.

The Indian Consumer Protection Act, was enacted in 1986 to provide for better protection to the interests of the consumers and settlement of consumer disputes and matters connected therewith. The act provides for a three-tier judicial machinery at the National, State and District levels to deal with consumer disputes relating to defective goods, deficient services, unfair trade practices, restrictive trade practices, hazardous goods, etc. In the recent past, a number of cases of negligence and apathy on the part of doctors have been brought before the consumer fora, and suitable compensation has also been awarded in genuine cases. As such, the health care providers in the country are now alert to the need of providing quality health care.

"CITIZENS CHARTER"

The main aim of the Citizens Charter is to raise quality, extend accountability and carry out the services fairly, effectively and courteously. The essential principles behind the charter are to ensure transparency, public participation and accountability as also quality, standards and value for money, besides providing information, choice and

a redressal machinery wherever possible. For too long the provider has dominated in the provision of health services, the focus now has to be on the user. Accordingly the Charter sees the public services through the eyes of those who use them.

Initially in the first phase, the scheme is likely to be voluntary. The providers of public utility service will be invited to apply for Charter Mark - a Special Logo, that signifies that the particular service has adopted the Charter principles. The Logo would signify that the concerned institutions, provide access to health care services at given times, maintain proper records, respects the patient's right to privacy, dignity, religious and cultural beliefs, have proper medical equipments, well laid down targets and standards of service and that there is an Advisory Committee in the hospital consisting inter-alia of representatives of people to monitor performance and, the charges for the services being provided by the hospital are clearly laid down. We have still to see how quickly and how well the concepts work.

At present, some State Governments are having a Nursing Homes Act and Rules under which the minimum standards in the nursing homes and small private hospitals have been stipulated and are expected to be monitored. By and large, even where registration has been done by the State authority of such small private hospitals and nursing homes, it has been found that it is difficult to keep up the tempo of monitoring in a manner which ensures observance of minimum standards.

Accreditation involves the evaluation of health care facilities performance. This is undertaken by senior members of the health profession using contemporary professionally

of a two tier system of medical care, expensive and high quality services for the rich, and lower grade services for the poor. It is for this reason the consumer groups have been asking for greater accountability of the private sector to ensure that the health care does not become a tool for exploitation of the vulnerable sections of the population.

Keeping in view the urgent need to regulate the private sector health care providers we have taken the following steps to safeguard the interests of the consumers.

The Indian Consumer Protection Act, was enacted in 1986 to provide for better protection to the interests of the consumers and settlement of consumer disputes and matters connected therewith. The act provides for a three-tier judicial machinery at the National, State and District levels to deal with consumer disputes relating to defective goods, deficient services, unfair trade practices, restrictive trade practices, hazardous goods, etc. In the recent past, a number of cases of negligence and apathy on the part of doctors have been brought before the consumer fora, and suitable compensation has also been awarded in genuine cases. As such, the health care providers in the country are now alert to the need of providing quality health care.

"CITIZENS CHARTER"

The main aim of the Citizens Charter is to raise quality, extend accountability and carry out the services fairly, effectively and courteously. The essential principles behind the charter are to ensure transparency, public participation and accountability as also quality, standards and value for money, besides providing information, choice and

a redressal machinery wherever possible. For too long the provider has dominated in the provision of health services, the focus now has to be on the user. Accordingly the Charter sees the public services through the eyes of those who use them.

Initially in the first phase, the scheme is likely to be voluntary. The providers of public utility service will be invited to apply for Charter Mark - a Special Logo, that signifies that the particular service has adopted the Charter principles. The Logo would signify that the concerned institutions, provide access to health care services at given times, maintain proper records, respects the patient's right to privacy, dignity, religious and cultural beliefs, have proper medical equipments, well laid down targets and standards of service and that there is an Advisory Committee in the hospital consisting inter-alia of representatives of people to monitor performance and, the charges for the services being provided by the hospital are clearly laid down. We have still to see how quickly and how well the concepts work.

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Accreditation involves the evaluation of health care facilities performance. This is undertaken by senior members of the health profession using contemporary professionally

established standards. This system has been successfully used in Australia. I would urge all the Health Secretaries to consider establishing a similar system in India, to provide accreditation, a kind of a star rating, as existing in the case of tourism industry, to a range of hospitals, from very small nursing homes to large hospitals and high-tech hospitals on the basis of their levels of service, efficiency as well as cleanliness. Accreditation will need to have the complete range of services evaluated by knowledgeable peers by establihsing autonomous bodies of State level professionals. Government needs only to give back-up support.

I would like to extend my best wishes for a fruitful discussion to all those who have gathered here and would be happy if concrete policy outcomes emerge from the deliberations of this workshop. I would also like to convey my thanks to the World Bank and the Government of Goa for their efforts in making this event possible. In particular I am glad that Dr.Feachem and Dr.Dean Jamison have come all the way from the United States to share global experiences with all of you.

I look forward to the outcome of this workshop and hope it would serve as a strong foundation for future developments.

* * *

ADDRESS OF

UNION HEALTH SECRETARY,

MR. P.P. CHAUHAN

THE HEALTH SECTOR IN INDIA

AN OVERVIEW OF SOME MAJOR CONCERNS

I am indeed very pleased to be present here today to participate in the three day Workshop on "Strategic Directions for the Health Sector in India". On my own behalf and on behalf of the Government of India, I extend a very hearty welcome to you all. This is an important Workshop and I am sure the deliberations here would contribute in a significant manner in improving the health care delivery system in India.

This is the second time that I have been posted in the Union Ministry of Health & Family Welfare, after a 5 year posting during the early eighties. I see a paradigm shift in the approaches to Health. What was essentially a period of establishing a wide infrastructure of primary health centres, sub-centres and community health centres throughout the country has opened up a wider panorama which includes stock taking of the shortcomings that the system has experienced over the years. There is now an increasing effort to see what can feasibly be achieved in the short, medium and long-term to contain diseases, promote healthy life styles and prevent illness episodes.

In the early 80's important policy initiatives like the formulation and adoption of the National Health Policy 1983, the Report of the Medical Education Review Committee which covered the entire spectrum of health manpower planning were brought before the Parliament. These policies were expected to lead to effective strategies which would in turn lead to healthier outcomes. A great thrust was placed on the Family Planning programme and augmentation of the infrastructure of important National Institutes like the All India Institute of Medical Sciences, New Delhi, the Post Graduate Institute of Medical Education and Research, Chandigarh. Disease control programmes for the eradication of Malaria, Leprosy, Tuberculosis, Blindness were under implementation. The funds allocated for health were, however, limited, available only through the National Programmes or by direct assignment of the Planning Commission to the

States. External donors either did not exist in the health sector or their contribution was small and specific.

On the other hand, in the nineties, we see a paradigm shift notable by the huge external aid which has become available for important disease control programmes. An ambitious project for conducting 11 million Cataract Surgeries in 7 years has been taken up in seven States of the country where the prevalence is comparatively high with a loan assistance of Rs.554 crores from the World Bank. The remaining parts of the country are being covered under the National programme. The establishment of District Blindness Control Societies in 472 districts of the country has provided a new impetus to the programme and is one of the prime examples of collaborative efforts which have succeeded under the leadership of the District Collectors. Already 2.5 million surgeries were conducted last year which has been a record for the country.

The National Leprosy Eradication Programme is under implementation with an outlay of Rs. 302 crores including assistance from the World Bank. The Leprosy case load has come down from 4 million cases in 1981 to .54 million cases at the end of March, 1996 and the goal of eliminating leprosy as a public health problem by the year 2000 appears possible. The main difficulties in the implementation of the programme have been: case detection of female patients; creating public awareness about the efficacy of drugs; and removing social stigma that is still attached to those who contract the disease.

The AIDS Control Programme did not exist in the early 80's. The campaign for AIDS prevention has been undertaken with a loan assistance of Rs.225 crores from the World Bank, entailing modernisation of Blood Banks, establishment of blood component separation facilities, operation of zonal blood testing centres and training of over 2220 doctors since the inception of the programme. The objective is sought to be achieved by ensuring blood safety, controlling sexually transmitted diseases, creating awareness and enforcing strict surveillance.

The Supreme Court of India has directed that Councils should be set up at the Central and State levels to co-ordinate the supply of blood and blood products and phase out professional blood donation in a time-bound manner. There are, today, a total of 1401 blood banks in the country out of which 486 blood banks in the public sector and 109 blood banks in the private sector are still unlicensed. Under the law, each blood bank has to be licensed and its licence renewed yearly after conducting joint inspections by the Central and the State Licensing Authorities.

The burden of tuberculosis is still a matter which daunts us. About 1.5% of the total population is estimated to be suffering from radiologically active tuberculosis. About 1.5 million cases are identified each year and more than 5,00,000 deaths occur every year due to TB. Some of the major concerns about the tuberculosis control programme include its weak management, inadequate supervision over treatment regimen, over-reliance on X-Rays for diagnosis of TB and poor quality of sputum microscopy etc. A tuberculosis control project which seeks to introduce short term chemotherapy for TB is at an advanced stage of negotiation with the World Bank for a loan of US $ 150 million. Under this project an estimated .35 million TB patients will be covered in a phased manner every year in 102 districts with provision for extending the projects to other districts in due course.

Of late, there has been a resurgence of Malaria. It is today one of the leading causes of illness in India and about 2.2 to 2.8 million cases are recorded each year. The constraints which face malaria control include inadequate operational support for undertaking timely spraying operations, lack of transport facilities, inability of medical teams to reach remote areas particularly in forest terrains, refusal of householders to allow spraying operations, resistance of the vector to the insecticide used, resistance of plasmodia falciparum to Chloroquine, weak technical leadership, large scale vacancies and frequent transfers among

key functionaries which affects surveillance.

A malaria control programme seeking World Bank and other external assistance, aimed at tackling malaria particularly in the rural areas is at an advanced stage of formulation. For the first time, synthetic pyrethroids, biocides and medicated bednets are being provided in view of the need to respond to special locational problems of insecticide resistance.

Control of Malaria during outbreaks is among the most pressing concerns of the Parliamentary Committees, State Governments, the media and the public. Much as we talk of community participation in promoting malaria control and propagating adoption of new strategies like the use of larvivorous fish, medicated mosquito nets and personal protection measures, we cannot contain the spread of Malaria by relying only on non-insecticidal methods. Our policy, therefore, seeks to phase out the use of DDT & BHC; reliance on the new generation insecticides is presently unavoidable.

Dengue has been a source of serious concern for us over the last two months in Delhi. There have been over 300 deaths and over 8000 cases. The spread of malaria, cholera, viral hepatitis and other infectious diseases can largely be attributed to the absence of adequate sanitation and environment health measures. After the outbreak of plague in 1994 there is a heightened interest in ensuring that a comprehensive national programme on sanitation and environmental hygiene is launched. There is an increasing realisation that there is need for urgently sensitising urban bodies for improving sanitation and cleanliness.

This has to be seen in the context of the urban situation which represents a quantum shift from 79 million people living in urban areas in 1961 to 217 million now. While the urban population increased almost eight times between 1901-91 the number of urban settlements only doubled. While almost 75% of the

population has access to water only 30% has access to sanitation. Whereas sanitation coverage is about 47% in the urban areas, it is hardly 14% in rural areas when almost 627 million people reside in rural areas. Some of the other major concerns are inadequate management of hospital waste, lack of co-ordination between solid waste management and urban land use planning, absence of health risk assessment and studies on solid waste management. Air pollution has further led to acute respiratory diseases and the lack of ventilation in slum tenements results in acute chronic conditions like Asthma.

As far as curative aspects are concerned, in most States, the treatment of out patient level illnesses is largely being provided by the non-Governmental and private sector doctors. On the other hand, in the case of hospital treatment, there is a much greater dependence on the Government system which often is found to be reeling under pressure for want of adequate budgets for maintenance, consumables, drugs and equipment.

While an impressive infrastructure comprising 2401 Community Health Centres, 21,802 Primary Health Centres and 1,32,285 Sub-centres has been set up through out the country for providing health care services, it has been found over the years that this infrastructure is working at sub-optimal capacity. In order to upgrade it an ambitious project has been taken up with World Bank Assistance of Rs. 2277 crores for upgrading the infrastructure in all district and sub-divisional hospitals in the States of Andhra Pradesh, Karnataka, West Bengal and Punjab.

This project represents a major initiative in financing and policy reform to increase efficiency and effectiveness of health programmes needed to be targeted at the State level. The project aims at strengthening the capacity of the State's health systems to deal with health problems at the district level. It aims at increasing Government expenditure on primary health care, improving and strengthening the referral system at the District and State levels, mobilising resources through user charges and strengthening the States' capacity for

strategic planning and analysis. It seeks to increase public awareness about health related issues and initiate community participation through interaction with the Panchayati Raj Institutions.

The project has evoked considerable interest among other States and project proposals have been received from several States for being included under this project in its ensuing phases. Huge disparities exist in some of our major States in the provision of health services. Now that the State Health Systems projects have made a successful beginning, we must use the opportunity to take care of a wider range of States, particularly those having large intra-State disparities or special problems.

An important area of concern is the manning of the Health services. Whereas the out-turn of medical graduates is colossal (17,000 a year), their actual availability in rural areas is notably deficient. 47.5% posts of surgeons, 51% posts of Obstetricians and Gynaecologists, 48% posts of Physicians and 43% posts of paediatricians are lying vacant in the rural areas. Similarly a number of posts of nurses and other paramedicals are also vacant.

The Central Council of Health & Family Welfare, the highest policy formulating body set up under the Constitution of India had resolved that in order to meet the shortage of doctors in the rural areas suitable amendments may be carried out in the Medical Council of India regulations laying down that permanent registration be given to MBBS doctors only if they have served in rural areas for 3 years. However numerous administrative difficulties have been cited in enforcing such a provision.

There is an increasing realisation that many of our important organisations and institutions like the Drug Control Organisation, the Prevention of Food Adulteration Organisation, the Vaccine Producing Laboratories are working at sub-optimal capacities. The provision of standards as per Good Manufacturing Practices, an

enforcement machinery which works, the monitoring of activities and promoting consumer awareness have admittedly been tardy.

Under the Drug Policy 1994, it was inter-alia decided to set up a National Drug Authority (NDA) by an Act of Parliament to be steered by the Ministry of Health & Family Welfare to look after the quality control aspects, rational use of drugs and related matters. It was also envisaged that a cess of 1% would be levied on the production of pharmaceuticals to encourage R&D activities. Recently the Government has also published a National Essential Drugs List for adoption in the country. An ambitious project for strengthening the Drug Control Organisation at the Centre and the States with World Bank assistance is under formulation for the strengthening of drug testing facilities in the States and augmentation of Drug Inspectorate staff.

Food is one of the basic needs for survival and it is imperative to ensure that whatever we consume is pure and wholesome. In order to upgrade the machinery for undertaking proper enforcement, both for testing of food samples and for taking deterrent and punitive action against those who are responsible for adulterating food items, a project has now been prepared to strengthen the National Food Control system. The project envisages strengthening of institutional capacity at the Central and the State levels, Central Food Laboratories, Food Safety Control at the State and District levels, establishment of Zonal offices and setting up management information systems. However, the success of this programme would depend very largely on awareness among the public that there is cause for concern and the system must be improved in a manner that the guilty are punished for infringement of the law.

The Ministry of Health & Family Welfare has been considering many options of making health facilities available to the poor, and had organised a workshop on 16th July, 1996 on the feasibility of widening the scope of Health Insurance in India.

The Government has also initiated Health Insurance Schemes for the hard-to-reach groups to have access to health care facilities. Two new health insurance schemes have been introduced by the General Insurance Corporation of India titled the "Jan Arogya Bima"(JAB) policy and the "Revised Medi Claim" policy (RMC). These policies cover hospital illnesses/diseases and injuries. Different heads of expenses paid to the insured person broadly cover board, consultation fees, and fee for other medical procedures.

The Jan Arogya Bima Policy is intended to benefit the low income group people as the premium ranges from Rs. 70 per annum for a total sum insured of Rs. 5000. Even a person below the poverty line can afford Rs. 70 per annum and cover the risk of diseases requiring hospitalization.

One of the recent decisions taken by the Government relates to treatment of poor patients who suffer from major illnesses, especially those involving long and complicated procedures. The Government has decided to set up an Assistance Fund to provide assistance to people below the income level of Rs. 11,000/- per year to enable them to get specialised treatment for life threatening illnesses and injuries. A sum of Rs. 30 crores has been provided by the Ministry of Finance, of which Rs.25 crores is proposed to be allocated to the States and Rs. 5 crores would be retained by the Ministry of Health for establishing a Central Illness Assistance Fund to take care of the needs of Union Territories without Legislature and reimbursing costs beyond Rs.1,50,000/- per individual in case of States and Union Territories with Legislature. However, this amount would only be of catalytic value and the main Fund would be financed through donations by individuals, corporate and non-corporate bodies, NRIs etc. All donations to the Fund operated at the Centre and the States would be exempted from Income Tax under Section 80 (G) of the Income Tax Act. The State Health Secretaries should take immediate action to set up such Funds. The Central Government will provide a matching grant against the amount contributed by the States upto a maximum of Rs. 5 crores.

Last but not least, I strongly feel that, surveillance of diseases is the key to the prevention and control of various diseases. We have decided to set up a functional Committee to give a thrust to the entire surveillance programme, upgrade epidemiological and laboratory support at the district and municipality level, for establishment of a network through the National Informatics Centre for easy communication. The provision of equipment, diagnostic reagents and kits for undertaking microbiological laboratory work through dissemination of information on disease profiles and measures for prevention and treatment are also receiving attention. There is need to strengthen epidemiological, bio-technological and entomological capacities and increase the capacity to perceive a threat, detect it, understand it and ensure timely response.

This does not in any way represent an overview of the entire health sector; it is an account of the major concerns and priorities that face us. I have gone through the operational perspective on the comparative review of the health sector reforms in the States of Andhra Pradesh, Punjab, Karnataka and West Bengal, with great interest. I consider the findings very interesting and useful. I am sure the deliberations in this important workshop will help us in evolving concrete policy options to effectively address some of the issues which I have brought out for improving the health status of the people of India.

I wish the deliberations of this workshop all success.

CHALLENGES IN THE HEALTH SECTOR

Smt. Shailaja Chandra
Additional Secretary
Ministry of Health & Family Welfare
Government of India

This unique gathering of the Central and State Governments, the World Bank, the World Health Organization, UNICEF, ODA and KfW provides an excellent opportunity to take stock of past achievements and to think about the challenges that are before us in the health and health related sectors. We are happy that the World Bank have also brought with them experts of international repute who will give us an insight into the process of health development across the globe.

We in the Health sector in India have seen enormous changes in India in the last 5 years. These changes have been of various kinds and are bound to trigger off a spate of new plans and new strategies in the years to come. At the beginning of the 8th Plan in 1992, we had a budget of Rs.1800 crores for the Central sector and Rs.5782 crores for the State sector (Chart-I).

Over the years, the Central budget has been increased mainly through a quantum jump in external assistance availed of particularly for the control and containment of diseases like AIDS, Leprosy and Blindness. New projects for TB, Malaria and Capacity Building of health institutions are on the anvil. Taken together, the outlay actually received from the Eighth Plan for the Central Health Sector has gone up from Rs.1800 crores to about Rs.2990 crores signifying an increase of 66%.

Within these outlays, dominant allocations have been made in favour of Communicable diseases followed by Medical Education in particular as far as the Central sector is concerned; comparatively, Hospitals and Dispensaries and Non-Communicable Diseases have received smaller outlays. Chart-II indicates this break-up. Within the Communicable Diseases, sub-sector outlays have been provided with the largest chunk going for vector borne diseases like Malaria, Kala-azar, Japanese Encephalitis followed by AIDS, Leprosy, Tuberculosis and Blindness (Chart-III).

At a macro level, gross allocations are passed on to the State Governments through the Planning Commission and through the conduit of National Programmes mainly covering assistance for drugs, consumables, insecticides and partial manpower support.

If one looks at disability, mortality and morbidity, the break-up can be summed up in Chart-IV. The leading causes of deaths due to different communicable diseases show that the number of deaths attributed to Diarrhoeal diseases, ARI and TB seen in the above manner make mortality due to other diseases appear insignificant (Chart-V).

Yet within the "other diseases", which account for 1% of all deaths due to communicable diseases, we have to contend with Malaria, Kala-azar, Typhoid, Japanese Encephalitis, Viral Hepatitis which are huge concerns for India as the afflictions are debilitating, affecting productivity and physical well being with attendant problems of drug resistance(Chart-IV).

Significant achievements have been attained despite what one may say, in regard to the reproductive and child health programme, the success of immunization or the contribution of supplementary feeding programmes. The level of life expectancy has been raised to 61 years, the Crude Death Rate has reached 9.2 per thousand and the Infant Mortality 74 per thousand. But these figures are not indicative of India as a whole. There are huge regional differences in regard to health indices (Charts VII (a) to (e)).

The Burden of Disease approach may not, therefore, as advocated in one of the Bank's papers circulated for discussion be capable of being operationalised. This would be particularly true in respect of reproductive health, family planning and a whole array of diseases. It would also tend to ignore the preventive aspects on which we need to focus much more attention. Over-reliance on the burden of disease approach will give skewed results from a planning point of view which we must avoid.

Challenge No.1 - Reducing Disparity and Inequity:

The first challenge, therefore, is one of reducing disparities and bringing about a modicum of uniformity among the States, within regions, within districts and within even Sub-districts. We need to have projects and programmes which specially address far

flung areas, backward and tribal districts and areas where communications bo electronic and transportation systems are weak.

Challenge No.2 - Building Surveillance Systems which work:

Surveillance does not start with Institutions howsoever well equipped they may b Surveillance starts with households, neighbourhoods, clustering of cases, ear reporting, house-to-house visits, timely blood slide examination and nipping the proble in the bud. But that does not happen today as so many outbreaks throughout the countr have shown, year after year. In Rajasthan when there was an outbreak of Malaria i 1994 in the desert districts of Barmer, Jaisalmer and Jodhpur which had never seer Malaria on that scale earlier, it came as a surprise to every one. The sudden outbreak o Dengue Haemorrhagic Fever in the Capital of India, New Delhi leading to 346 deaths and 8,843 cases was so sudden, so unexpected and unprecedented in magnitude and it took all the might of the Government supported by so many expert agencies, public health experts, clinicians, communication experts to be able to control the situation in 50 days. Meanwhile over 1700 deaths of which almost 900 are said to be fever related deaths with malarial manifestations had occurred in the adjoining district of Gurgaon considered by many to be a part of suburban of Delhi and otherwise a small pocket of in the comparatively developed State of Haryana. Recent surveys conducted in the locality have shown that the Haemoglobin levels of the women and children have ranged between 2 to 6. While experts have their own views on whether anaemia was caused by a two year endemicity of Malaria in the flood affected district or Malaria was caused by anaemia, the fact remains that thousands of people have died in just one small part of a single district.

We need to develop a rapid action health reinforcement team available capable of responding with speed, technical and managerial efficiency whenever such outbreaks occur. There is an overwhelming need for surveillance system which works, manned by specialised people capable of responding to special situations. This calls into question another challenge. Should we not be making it enforceable for health risk assessment studies to be undertaken every time a developmental project comes up?

High mortality/morbidity levels are, for the most part, attributable to factors like quality of drinking water accounting for gastroenteric cases and deaths due to diarrhoea.

The root cause of Malaria and other vector borne diseases is the proliferation of mosquito breeding grounds created largely by factors like stagnation of water around irrigation and developmental projects, labour migration, vast tracts of no-man's land owned by what is euphemistically called Revenue land, over which any one holds claim but for which no one is accountable, leading to the spread of the Anopheles, the Aedes, the Culex mosquitoes, responsible for the transmission of Malaria, Japanese Encephalitis, Kala-azar and Dengue. Outbreaks are not an Indian phenomenon. Chart-VIII, derived from a Centers for Disease Control(CDC), Atlanta study, shows that the early nineties have seen this phenomenon across the World.

CDC has developed a surveillance and response system aimed at detecting, investigating, developing control measures, undertaking applied research, enhancing public health information systems through epidemic intelligence services. The epidemiological services are aimed at preventing and controlling public health crises, both biological and chemical. A surveillance telecommunication system links CDC with 50 States and provides weekly transmission data on over 40 infectious diseases. Our challenge is to draw from such systems, build on them, strengthen the National Institute of Communicable Diseases, the National Institute of Virology at Pune, the Malaria Research Institute at Delhi, establish regional and State level networking systems and put back into place epidemiologists, microbiologists, entomologists who have disappeared from our mindset. We need to support more schools of public health, better networking system and establish rapid response teams, more like a territorial army capable of helping States and districts in distress.

The Chief Secretary of every State had been requested by the Department of Health to set up High Powered Boards in which all persons connected with agriculture, water resources, urban sanitation and health were involved. Some States have done this. Some have stated that there are already too many Committees. Be that as it may, the real eyes and ears of the health sector are our ANMs, Multi-Purpose Workers, ICDS workers and voluntary workers. Some one has to respond to what they have to say and respond with concern and a sense of accountability for what might happen. To that end, it is important that inter-sectoral committees work to see that the watchdog is alert and not in a state of slumber. The challenge lies in building surveillance, rapid response and public health systems which work and are accountable.

Challenge No.3 - Making those responsible for Health Hazards Responsive:

Should the people who create problems unmindful of the health risks that they a generating, not be required to make financial and administrative provisions for tacklir public health outcomes as an integral part of project formulation and proje implementation? The World Bank had taken this up sometime ago with the Governmer Independent of this, the Ministry of Health took this up with Health Secretaries and Chi Secretaries of every State as well as Union Secretaries in charge of Water Resource Agriculture and Urban Development. The challenge before us is how to make thi happen without promulgating another legislation. Can we ride piggy back on th Environment Protection Act? Can we insist on a components like essential dispensar and laboratory facilities to be provided whenever large projects come up which have propensity to create health hazards? Can we make health risk assessment studie integral to project formulation?

Challenge No.4 - Decentralization in Planning and Implementation:

Today we have a water tight structure which requires funds to devolve through th Planning Commission to the State Government who slice the cake, give Health sector it share which in the fullness of time percolates down from the State to the Districts an Sub-districts through time honoured systems and channels. Gujarat and Maharashtra States have by years of experience in implementing the Zilla Parishad system. Sometimes the Centre and States administer health programmes vertically with decentralization at the District level. We have experimented with such District Societies with varying results. The District Blindness Control Society has been, at least until now, a shining example of integration, collaboration and co-operation between the Government voluntary agencies and the private sector. But the goal there is to restore vision through a simple operation. Indeed a rewarding goal. The same holds true of Leprosy Societies. We have to see whether such a concept can take off in the area of Malaria which is no-man's problem and no-man's responsibility, till the disease strikes.

In recent and repeated examples in Delhi it was found that the Aedes mosquito was breeding in water-coolers in the most affluent homes, in flower pots, flower vases, in bottles and cans inside homes, in garages and in areas which are strictly domestic property. Can one expect government to enter each and every nook and corner of

people's homes? Education through print and TV media was possible in Delhi, but the same strategies may not work, if for example the outbreak occurs in rural Madhya Pradesh or Orissa. The challenge before us is how do we bring a sense of personal responsibility? Time and time again we have attributed lack of awareness to low levels of literacy, poor media efforts, abysmal health education efforts and the like. The challenge is how do we decentralise and take such tasks out of Government's responsibility. There have been illustrious examples of free advertisements of high quality being sponsored free of charge by the private sector for AIDS, Tobacco and Cancer Control. Industrialists have put money into advocating many measures considered to be supporting a worthy cause like establishing bathing platforms at railway stations in Bombay and bearing the illumination costs of monuments of historical importance in the city.

The challenge lies in building partnerships with the private sector and farming out to them responsibilities for ready packed health awareness messages for which they can advertise their name. I always remember the case of a District Collector of Faridabad who was able to make a special dent during the formulation of the Blindness Control Programme. We were told that he had been able to quadruple cataract surgeries in his district and on principle had not taken a single rupee from the Government. As Collector, he tapped the resources of the entire group of industries in his district and obtained donations in the form of bandages, sutures, bedsheets, vehicles on loan, free food for the patients etc. He refused cash donations at all cost. In Rajasthan while on election duty I was amazed to find wards in standard Community Health Centres consecrated in marble in the name of a revered father or mother whose first class passage to heaven must have been assured. Examples of donation and charity abound in Indian society.

Challenge No.5- Integrating Programmes:

One of the biggest challenges before us is that of improving technical efficiency of programmes where today functions are duplicated or compartmentalized. This will continue as long as funding and donor agencies push the "flavour of the year" concept. Although the creation of organizations like NACO have played a useful purpose, some grey areas do persist in the programme. Sexually transmitted diseases are today a part of NACO's responsibility. But this area has overwhelming interface with reproductive health. Side-by-side there is increasing evidence that more and more AIDS cases are emerging through the route of TB.

The challenge lies in finding linkages both vertical and horizontal. The debate has been going on for years. We have discussed the idea of integrating departments, of blending programmes, networking at the grassroots levels. But this just does not happen because people in their very nature tend to look to their paymasters as their bosses. Be it the Regional Directors Office of the Directorate General of Health Services located at 17 places in India or the humble multi-purpose worker, what differentiates primary responsibility from secondary responsibility is who pays the salary.

Perhaps the time has come to change the focus of planning and think of experimenting with an entity called the District Health and Welfare Manager. It is possible to conceive of a person, whether from an administrative background or a medical background who could he be entrusted with the total responsibility of planning for health and attendant matters keeping in mind the epidemiological transition, growing disparities within the district, issues of urban health by providing a focus to locating problems backed by a knowledge and understanding of the district.

Theoretically, it may be possible to consider devolving resources through the State to the District Health Manager who if possible could also be given control over nutrition and family welfare schemes which go hand-in-hand with health. Many schemes and projects have already been entrusted to the Collectors of the districts. They are the kingpins of the districts and are responsible for developmental as well as regulatory activity. Whether one calls him the Chief Executive Officer or the Zilla Parishad or the Deputy Commissioner of the District, the fact remains that things revolve around this focal point and the system has worked. But the time of this focal point is spent on many things. Health, Family Planning and Women & Children's welfare is only a small part of his activity making him answerable and accountable for epidemics and outbreaks only when they occur.

The State of Goa has a population of just 1.1 million according to 1991 census. This constitutes a smaller population than many districts in India. Yet the State has a Governor, a Chief Minister, a Deputy Chief Minister and 14 ministers. They are all busy and have managed to carve a niche for themselves and find plenty of work to be done throughout the year. I had the good fortune of serving this haven on the West Coast of India for $3^{1/2}$ years and I had no problem finding work to do. If such a tiny State which is half the size of an average district can find work and meaning to sustain such a huge hierarchy, isn't there a case for a higher and more integrated level of management at the district level? The States of Manipur, Meghalaya, Mizoram and Nagaland also have tiny populations. But they have got Statehood based upon various other factors and their land area is immense. If we are committed to improve health should there not be a better infrastructure for health and allied social services at the district level?

Having worked in the State of Maharashtra where the Zilla Parishad system was trong even in the sixties, one could appreciate the pivotal role of the Chief Executive fficer of the Zilla Parishad. But even he can deliver only upto a point. There is no way CEO, a collector, a District Health Officer or a CMO can tackle epidemiological utbreaks, plan for variations within the district, involve the medical fraternity and ommunity in planning for the problems of Cancer, Cardio-vascular diseases, mental lness, geriatric problems which are going to grow in the next 15 years. Daily demands rom Agriculture, Education, Public Works and Electricity are much more pressing and ime consuming and will dominate the scene. The time has perhaps come for another Chief Executive Officer whose whole-time job is to look after Health, Family Welfare and Women & Child Welfare, a man who is no lower in the pecking order than the Collector or CEO but to whom the vertical channels are responsible.

Challenge No.6 - Planning from Below:

If for a moment the district is seen as the fundamental area at least for health sector planning, what then would be the implications for National programmes, State priorities and integration with other sectors? The question one must ask is how would the resources be managed? How would one achieve the process of delegation downwards and accountability upwards? Establishing a third focus of authority would signify huge implications for Government rules and regulations, budgetary process and financial accounting systems. The concept even if we push it to the hilt even on an experimental basis will need clearance of political masters, donor agencies and turf guarding bureaucrats and the employees associations? The challenge lies in making a beginning howsoever small.

Challenge No.7 - Health Financing through Autonomy:

The financing of health schemes is unending. Higher expenditure begets still higher expenditure. There is no end to what one can spend on construction, maintenance, drugs, consumables, equipment and staff salaries. The whole process is mind boggling as no one sector can be neglected and no one action howsoever laudable can be taken without a financial fall out and implications for sustainability. In the meantime, communities have been known to work for their own good and Raliganj Shinde in Maharashtra under the able leadership of Anna Hazare is a shining example of such success.

It is, perhaps, time that Government considered whether it is possible to offload the running of Community Health Centres to a Board of Management selected or elected from among the people of the area. The Board could be managed by a Sub-divisional officer assisted by a nominated secondary level school or college teacher, leading private

practitioners, a leading lawyer or industrialist and having ex-officio membership from among the senior most officers in the district as well as the Community Health Centre. They could be given the authority and flexibility to raise finances, levy charges for services, declare the improvements they would like to bring about in a given year and be assessed in terms of quantifiable targets accepted by Government. The autonomous board could be given flexibility to contract out services for doctors' services, maintenance, laundry, sanitation and food.

The system works quite well in the case of some Institutes like the All India Institute of Speech & Hearing, Mysore and the Pasteur Institute of India, Coonoor which are Central Government institutions administered from Delhi but having the autonomy to take decisions within Government rules and regulations. Andhra Pradesh and Punjab have selectively opted for the Corporation model. Stabilization of the idea may take time but it has taken a high sense of conviction to have introduced the measure. Madhya Pradesh has introduced user charges in some State owned hospitals and already tried the strategy of autonomy. We would like to know how successful the strategy has proved in providing autonomy in the use of these resources.

At the Central level, we have been discussing various ideas like moving from a strictly Government orbit to that of autonomous institutions or even to a public sector or joint sector enterprises. The Medical Stores Organization of the Government of India responsible for all drugs purchases, the vaccine producing laboratories at Central Research Institute (Kasauli), the B.C.G. Laboratory (Guindy, Chennai) are ideal organizations which would benefit from managerial expertise, professionalism and the flexibility of raising institutional finance. JIPMER, Pondicherry, one of the flagships of the Central Government could benefit hugely from autonomy which has been strictly resisted by Class-IV association of the medical-teaching and research Institute.

The challenge will lie in managing or overcoming union resistance, press criticism, judicial pronouncements, parliamentary questions which are part and parcel of the working lines of world's largest democracy. But if we can succeed even to a small degree in making a beginning through a process of consultation and solidarity, it would pave the way for wider changes in the future. The Health Department of Tamil Nadu have shown the way to some extent in their Drug purchase system. We would like to hear more about that experience.

The same idea also needs to be extended to financing tertiary services. We ought to consider giving autonomy to State Hospitals to be run by Boards on which there are elected representatives as well as community leaders. This would enable the facilities to raise extra endowments and donations. They would be able in a position to charge for the

- Industrial houses should make available funds for maintenance of sanitation and environmental health as it affects the health of employees.
- Introduction of Municipal Bonds
- Introduction of professional tax for housing activities
- Introduction of environmental health and sanitation cests while fixing charges in hotel, cinema halls, theatres, hospital facilities.

Another example of what is still to take off but which is within the realm of reality is the concept propagated by the World Health Organization in its theme for 1996 - The Healthy City Concept. A beginning is now being made in the Trans Yamuna area of Delhi in a project undertaken by the State Government and supported by WHO. In this project there has been an effort to integrate all the Departments concerned with Health, actively or passively. The idea is to generate competitions for healthy schools, healthy neighbourhoods, healthy dispensaries, healthy markets and many others. Funds already available for the disease control programmes, education, health awareness, publicity are being intermeshed to be able to give an integrated plan for creating a healthy city movement among a section of the public through a calendar of events. Only time will tell what kind of impact the project would have. But as an idea and as a launching pad for better integration it is a promising concept.

Conclusion:

The foregoing presentation does not necessarily represent the views of the Union Ministry. It has been made on a futuristic plane to throw up issues for discussion. I would consider my job done if I can get a response from my colleagues in the Ministry and in the State Governments many of whom have been front-runners in effecting changes, quickly, unobtrusively but with an eye to the ultimate goal - improving the health system we all serve.

services on account of increased costs and increase the charges depending on escalation in costs. They would be able to determine through a direct process the groups to be exempted from paying charges and enforce efficiency by having the authority for running facilities. They would not need to run to the Departments of Health as long as they consult Government on staffing standards, quality of care and other regulatory matters.

Government would only need to provide annual grants and it would be left to each facility to function according to a Memorandum of Understanding the output of which should be counter-checked by Government each year. The performance of the hospital as per the MOU would be a target for judging the performance of the Government nominees and sufficient reason to continue or dispense with the services of the non-Government nominees. The Board could accordingly be revamped every two years based on performance.

Challenge No.6 - Bringing Environmental Health & Sanitation high on the National Agenda:

There are enormous differences in the availability of infrastructure in medical public health services between rural and urban areas. Only 31% of the hospitals, 22% of the dispensaries and 16% of the total hospital and dispensary beds are in the rural areas whereas 74% of the country's population is located there. In 1961, almost 30% of the medical personnel were located in rural areas. Today the proportion has declined to 21%. The cause of ill-health and the factors which contribute thereto become very important in trying to bridge the gap. The Ministry of Health had in the wake of Plague in 1994 convened a Group comprising the Union Secretaries of Urban Affairs, Rural Affairs, Environment & Forests and Health. Issues connected with sanitation, solid waste disposal, liquid waste disposal, prevention of diseases and building up health awareness were thrashed out on the basis of working papers supplied by each Ministry. It was an unique opportunity for four Ministries to get together and have an interface with one another to understand what was seen to be a joint problem. The aim was to try and bring Environmental Health and Sanitation high on the public agenda. As a result of this exercise, an ambitious project was drawn up on the lines of a Technology Mission. The quantum of funds required for such an ambitious project was naturally of gargantuan proportion. Presently each Ministry has been asked to consider the recommendations and prune the proposals to bring them within the realm of reality during the 9th Plan. Some of the innovative ideas which have been advanced by the Group of Secretaries included:

- Generation of funds through an environmental health cess to be used for sanitation linked activities.
- Promoting enterprises for collection of urban waste and its transportation.

EIGHTH PLAN HEALTH SECTOR OUTLAY
(Central/States/UTs)

(Rs. In Crores)

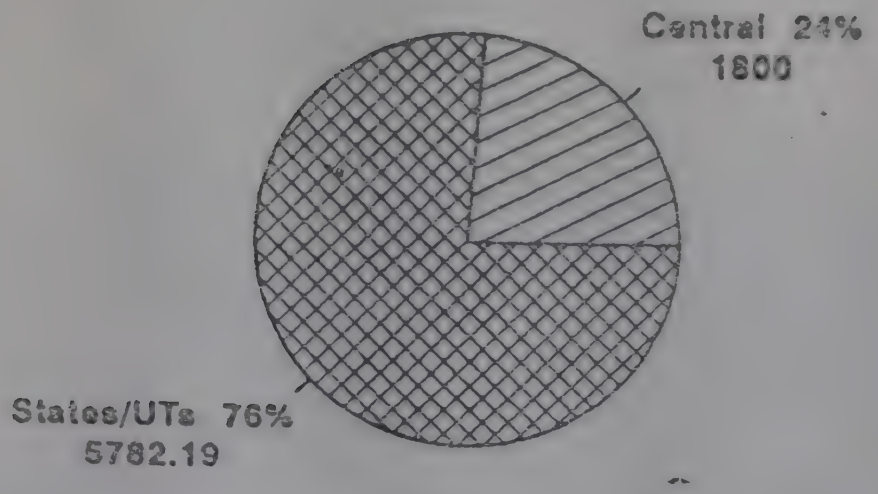


CHART - I

CENTRAL SECTOR HEALTH PROGRAMMES
(ALLOCATION FOR EIGHTH PLAN)

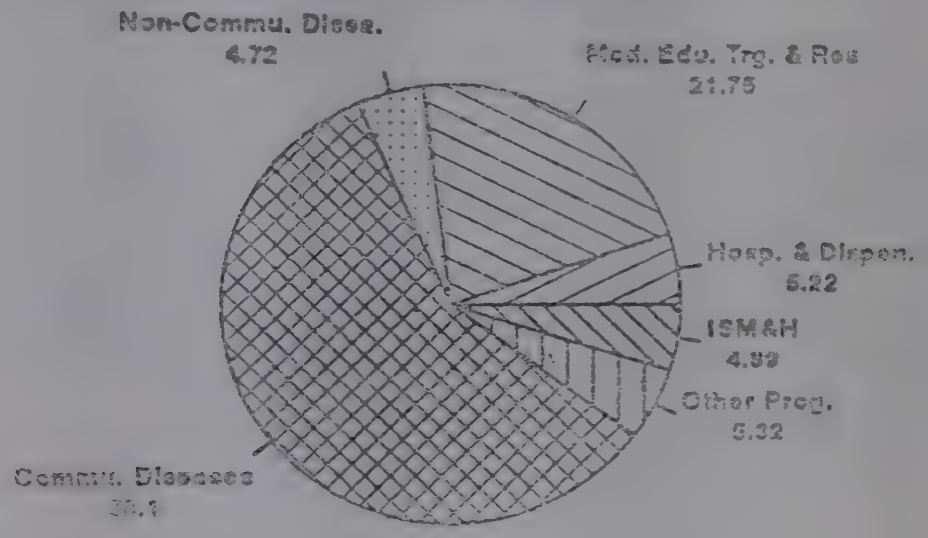
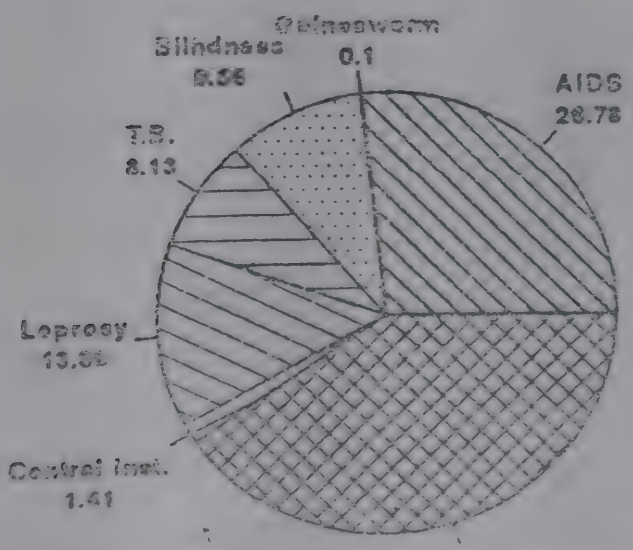


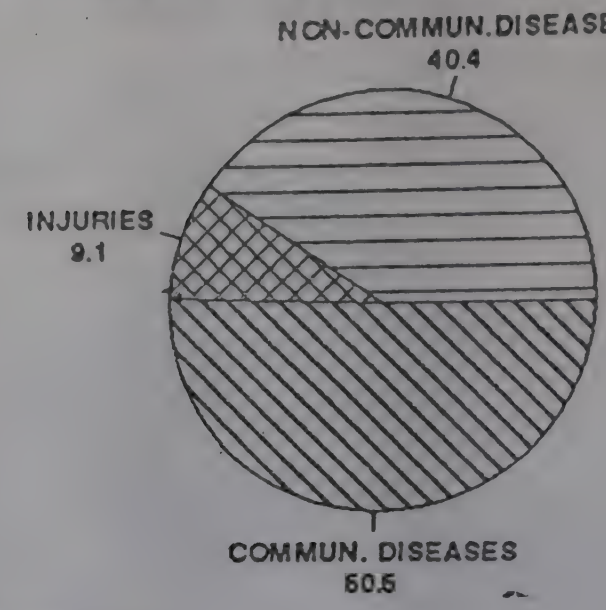
CHART - II

EIGHTH PLAN CENTRAL SECTOR ALLOCATION FOR COMMUNICABLE DISEASES



Vector born diseases like Malaria, Kala-azar, J.E. etc.
40.56

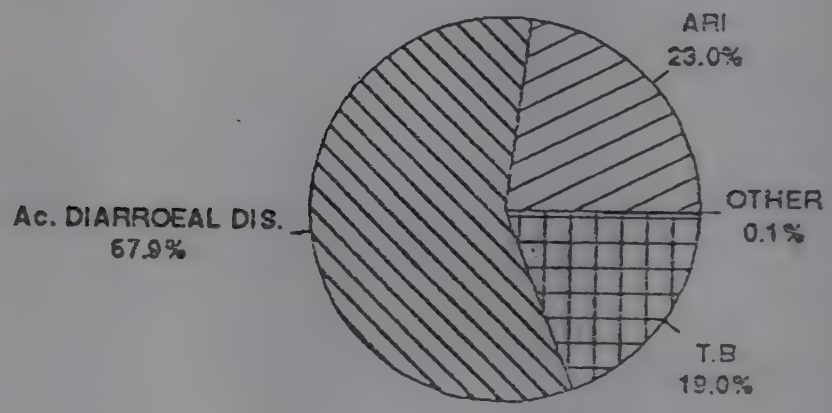
LOAD OF DISEASE BURDEN BASED ON DALY (Disability linked Life Years) LOST



SOURCE: NICD

CHART - IV

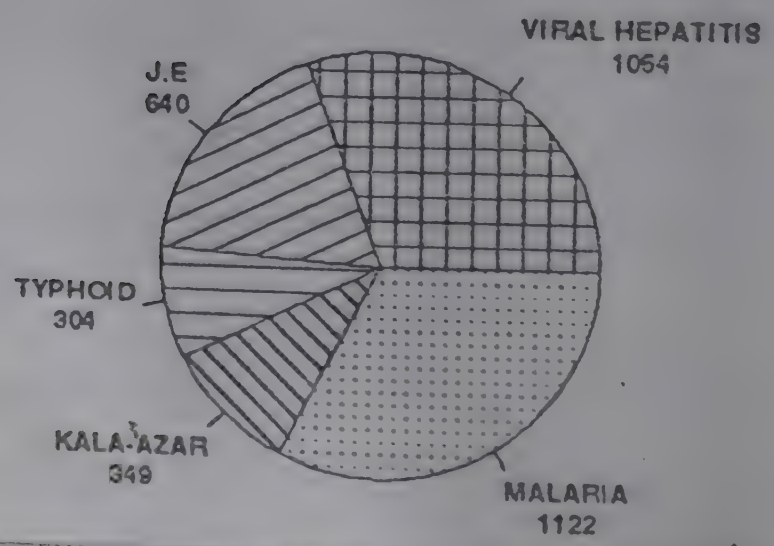
LEADING CAUSES OF DEATHS DUE TO DIFFERENT COMMUNICABLE DISEASES IN INDIA ON GROSS ESTIMATIONS FROM 1990-1994



SOURCE : NICD

CHART - V

MORTALITY FIGURES OF " OTHER " DISEASES IN 1994



INFANT MORTALITY RATE
SELECTED STATES

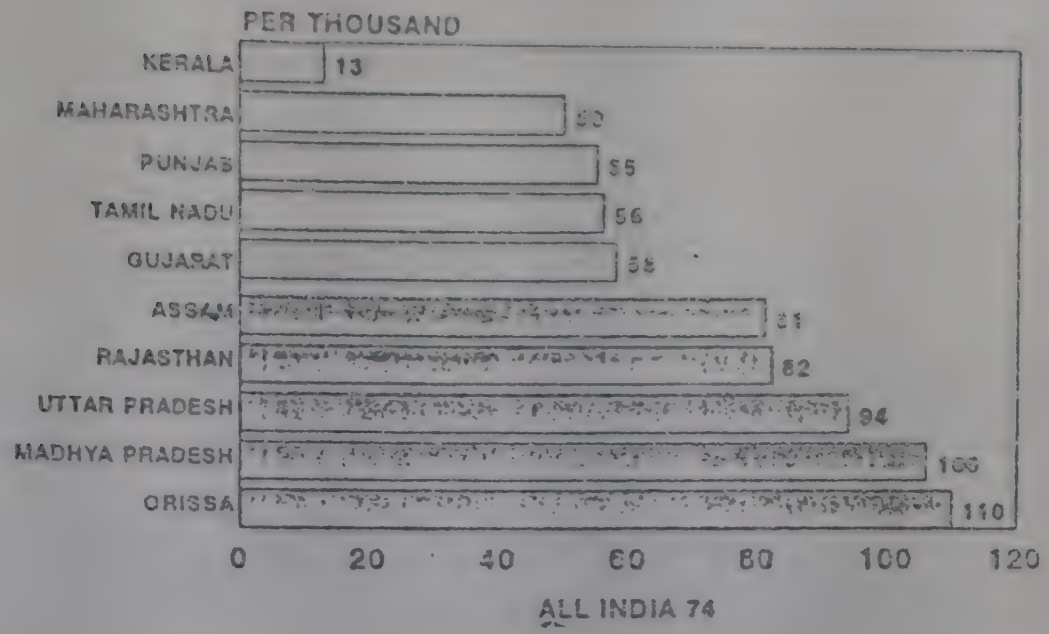


CHART - VII (a)

CRUDE BIRTH RATE
SELECTED STATES

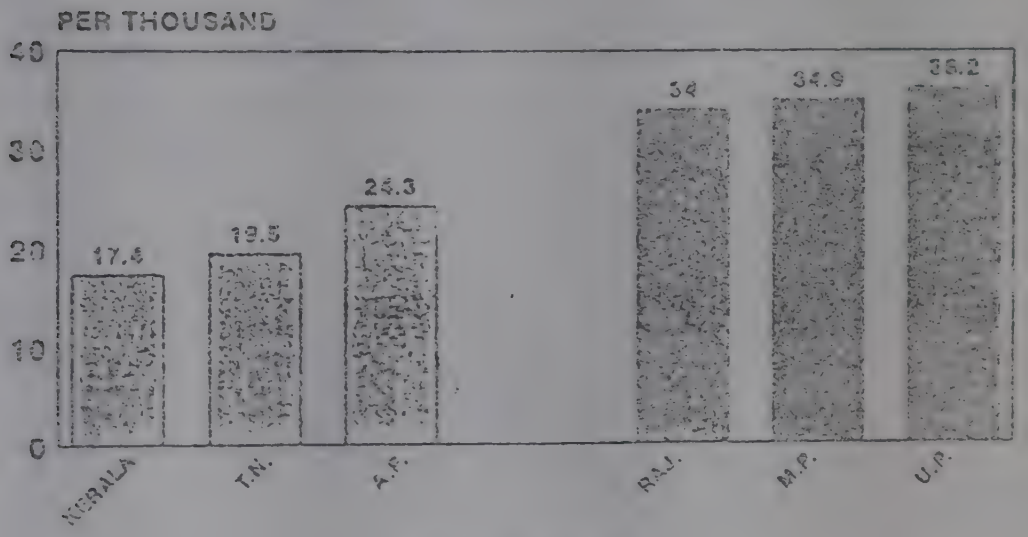
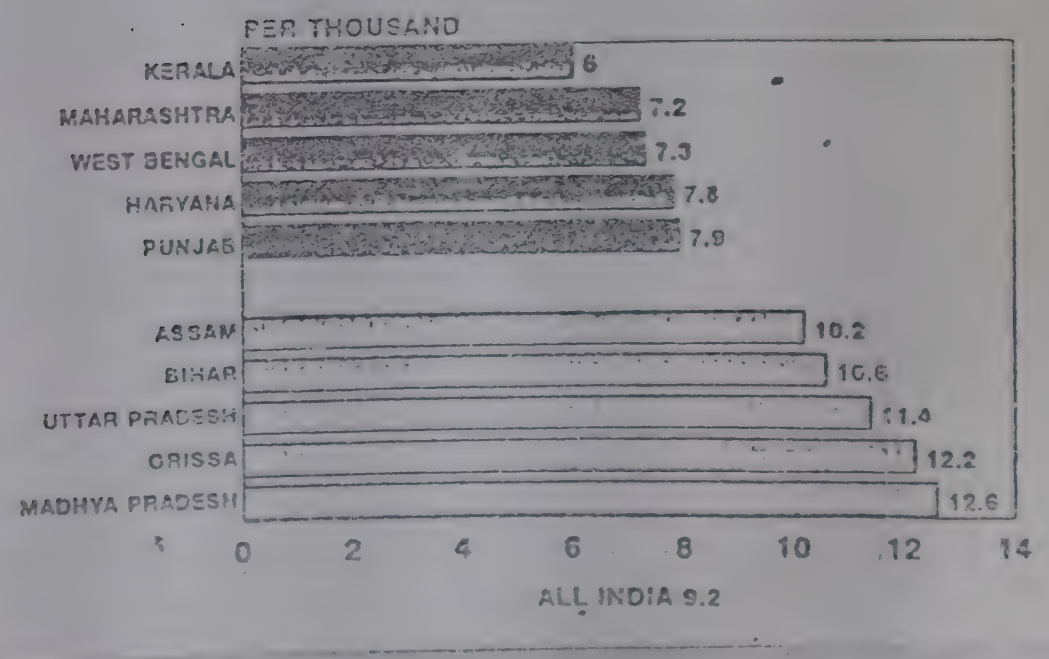
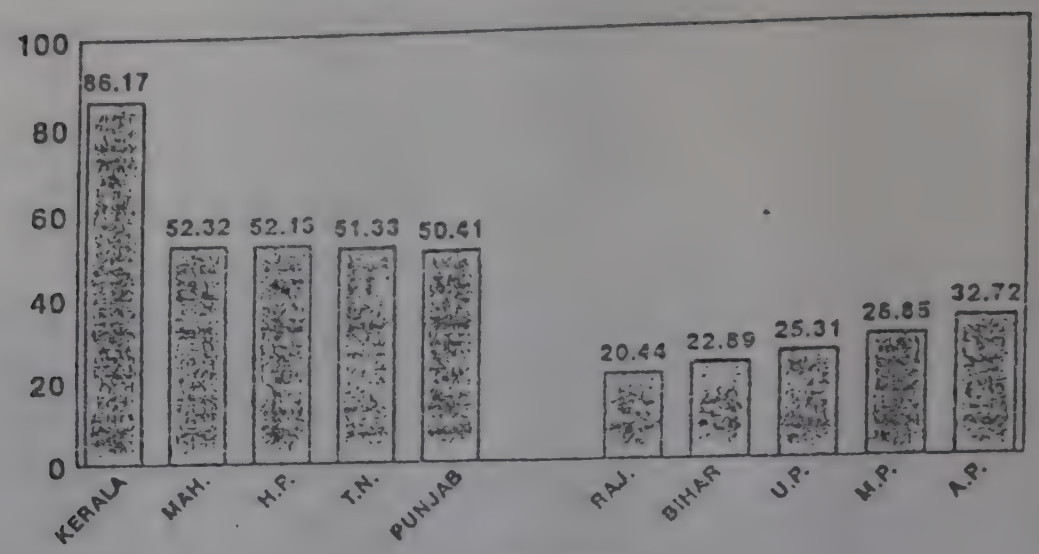


CHART VII (b)

CRUDE DEATH RATE
SELECTED STATES



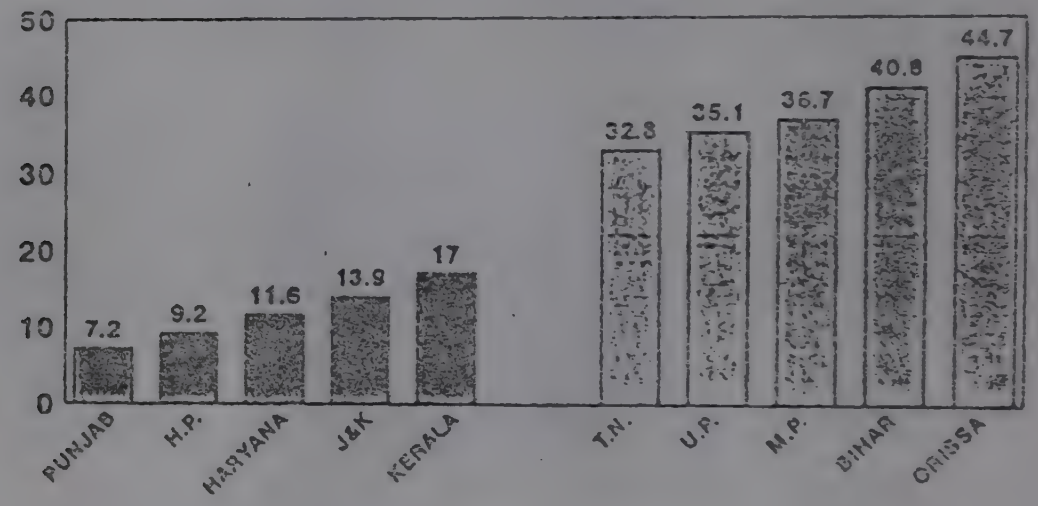
FEMALE LITERACY
SELECTED STATES



ALL INDIA 32.2

CHART VII (d)

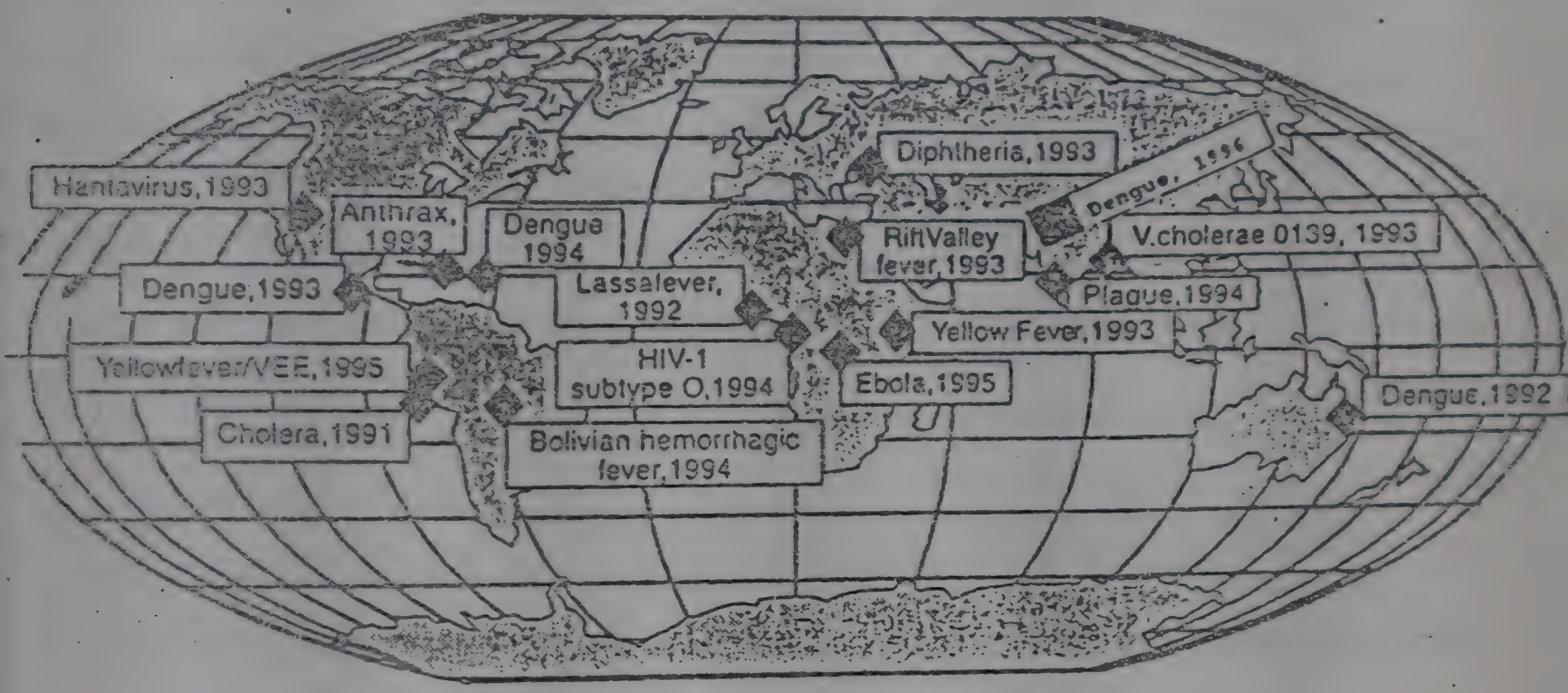
PERCENTAGE OF POPULATION BELOW POVERTY LINE
SELECTED STATES



ALL INDIA 29.9%

CHART - VII (e)

Examples of New and Reemerging Diseases in the 1990s



CHART

ANNEXURE VI

78

THE HEALTH TRANSITION AND THE UNFINISHED AGENDA

ANTHONY R. MEASHAM
WORLD BANK

The health transition refers to changes in health status of populations as they move from high mortality and fertility to low mortality and fertility - the passage from a predominant pattern of communicable disease (CD), maternal (M) and prenatal (P) conditions to a picture dominated by Non-Communicable Diseases (NCDs). I would add undernutrition to the unfinished agenda, since it is associated with about half of the deaths of children under five. The unfinished agenda is dealing with CD, M & P conditions.

India has made great progress in improving the health status of its people over the last 40 years. The increase in life expectancy from the low 40s around 1950 to 62 in 1994 is a major achievement. Under five mortality has also declined very substantially - by nearly half - from over 200 per 1000 around 1950 to 123 per 1000 in 1994.

For the last 30 years, the health transition has been underway in India. Fertility has declined by two - fifth, the population structure has aged, and mortality from communicable diseases has declined. NCDs have become a larger and larger contributor to morbidity and mortality. Over 50% of deaths in India are still caused by the unfinished agenda of communicable, maternal and prenatal causes (Fig. 1). But by 2020, this expected to decline to 21.5%.

When we look at Disability Adjusted Life Years (DALYs), the picture is much the same (Fig. 2) in 1990, the unfinished agenda accounted for 56% of DALYs; in 2020 it will probably account for over 24% of DALYs. Note the increase in the toll of injuries, from 15% of DALYs in 1990 to 19% in 2020. Furthermore, the NCDs will account for a very large quantum of preventable morbidity and mortality. And, if this quantum is not prevented, the economic costs of India will be enormous.

The Health transition is basically driven three components. An aging population, various specific risk factors, and access and use of preventive and curative health services. The risk factors and health services can be modified. This is far less the case for the demographic engine driving the health transition.

Fig. 3 shows selected risk factors. Tobacco use looms very large, and will account for 13% of deaths by 2020. Therefore, notwithstanding the fact that the unfinished agenda is still top priority for India, the rise of NCDs must be addressed. A start has been made in this regard but a great deal more needs to be done.

Clearly, the basic principles are two:

1. To prevent NCD whenever possible, largely through primary and secondary prevention.
2. To invest in preventive and case management interventions of low cost and high effectiveness.

Three areas deserve special priority attention:

1. Effective Tobacco Control: Health promotion, education, legislation and taxation, tobacco units.
2. Low-cost and widely accessible secondary treatment of common chronic diseases e.g. Cardiovascular diseases and cancer.
3. Mounting a massive health information and health promotion campaign regarding lifestyle, with particular emphasis on tobacco control and Cardiovascular Disease (CVD).

A few examples of poor investments in NCD control are Bone Marrow Transplant Programme, Trauma Center, High-technology cardiovascular disease patient care center and stadiums for encouraging physical fitness.

The two areas where India, despite all the progress it has made in health, lags seriously behind most other countries in the world are undernutrition of women and children, and women's health. These two are closely related.

53% of India children under five are moderately or severely malnourished. This proportion is exceeded only by Bangladesh and is much higher than most African countries. No African country for which reliable data are available tops 50%. 30% of Indian children are born with Low Birth Weight (LBW), which greatly diminishes their chances of survival. Malnutrition has a huge impact on child mortality

India's under five mortality is now 123, and is made up on 73 infant death and 50 deaths at age 1-4. Given the success in dealing with post-neonatal mortality. Two-thirds of infant mortality occurs in the first month of life and at least 50% is related to LBW, which carries a substantially increased chance of mortality in the first month.

Conditions in India are extremely diverse. For example, infant and child mortality in some urban slums is higher than in most rural areas of the deprived states. There is a contrast in child mortality between Kerala and the states of the Hindi-belt. There is some evidence that the infant mortality and under 5 mortality rates have plateaued in India, even in advanced states like Tamil Nadu. Major reasons are LBW and undernutrition of women and children, which are closely related. Even if we become ever more successful in dealing with acute respiratory infections and diarrheal disease. The chances of reducing mortality and morbidity are greatly reduced, in the face of undernutrition and LBW babies. Most children do not die from a single attack of a single disease, but succumb to a downward spiral caused by multiple infections in a malnourished individual.

Women, too, are malnourished in India. About 80% of them are anemic, most of them gain too little weight in pregnancy, and they are overburdened with work. All of this adds up to the very high incidence of LBW and contributes to the high maternal mortality rate of 437 per 100,000 live births.

WOMEN'S HEALTH

At 927, India's sex ratio is among the lowest in the world, leading Prof. Amartya Sen to speak of the country's 50 million missing women. Some have argued that this anti-female bias is the single biggest development challenge the country faces. Certainly, it is a major determinant of the poor health and life expectancy of women, and the high infant and child mortality.

In contrast to most countries, life expectancy for women under 30 is lower than for men in India. The main reasons are foeticide, infanticide, inadequate nutrition, less health care, early marriage, and premature child bearing. Other major problems relating to women's health in India are neglect of reproductive tract infections, sexually transmitted diseases, high incidence of reproductive tract cancers and vulnerability to HIV; lack of treatment for common health problems, and lack of gender-sensitive approaches, reproductive health care is only part of the need. Non-reproductive health care is equally important.

If undernutrition and women's health are major priorities for India, as part of the unfinished agenda, what can be done about them? Four priority actions are proposed:

- **Female primary education**
- **A women and child first policy in health services**
- **Prevention of undernutrition**
- **Nutrition interventions.**

The main malnutrition diseases are protein energy malnutrition, vitamin A deficiency, iodine deficiency and anemia (lack of iron). The major causes of malnutrition are lack of income and food security, high prevalence of disease, and lack of knowledge.

Six potential areas for improving nutrition are control of infectious disease, nutrition education, micronutrient fortification, micronutrient supplementation, food supplementation and food price subsidies. Nutrition interventions are among the most

cost-effective interventions available. Fortification with iron, iodine, and Vitamin A and food supplementaries are cost-effective, with cost per DALY gained of $ 4-13, $ 8-37, $ 1-4 and $ 24-63 respectively. These are comparable to child immunization. With regard to micronutrient malnutrition, task force report is soon to be released. The key question is, which agency or agencies will be charged with developing a multisectoral strategy and implementing it.

THE HOW OF TACKLING OF UNFINISHED AGENDA

The responsibility for nutrition is divided in the Government of India. The Department of Women and Child Development(DWCD)/Ministry of Human Resource Development (MOHRD) is the nodal Ministry; the Ministry of Health and Family Welfare (MOHFW) is in charge of Maternal and Child Health, which includes nutrition education, Vitamin A and iron in the Department of Family Welfare, and iodine deficiency disorders are the responsibility of the Department of Health.

The Public Sector delivery system is also divided: MOHFW has one Auxilliary Nurse Midwife (ANM) for every 5000 (often 7,000 to 8,000) population. She is overburdened and cannot effectively reach the villages in her catchment area. Only at the village level can pregnancies be identified early enough, pregnancy complications be referred in good time. And undernutrition and LBW be prevented. By the age of 14 months, the vast majority of children who will be malnourished already are. The die is cast and their human potential is diminished. The Departments of Women and Child Development and Social Welfare have an Anganwadi Worker (AWW) for every 1000 population who lives in her village. She is responsible for growth monitoring, nutrition, education, pre-school education and supplementary feeding.

Convergence of the ANM and AWW is gaining momentum. In many places, these two workers are starting to work together, especially on immunization. At GOI and State Levels, Health and Family Welfare and Social Welfare Ministries are beginning to join forces, to organize joint training of ANMs and AWWs, and to combine activities, e.g., Antenatal Clinics at village level. Only through this conference can

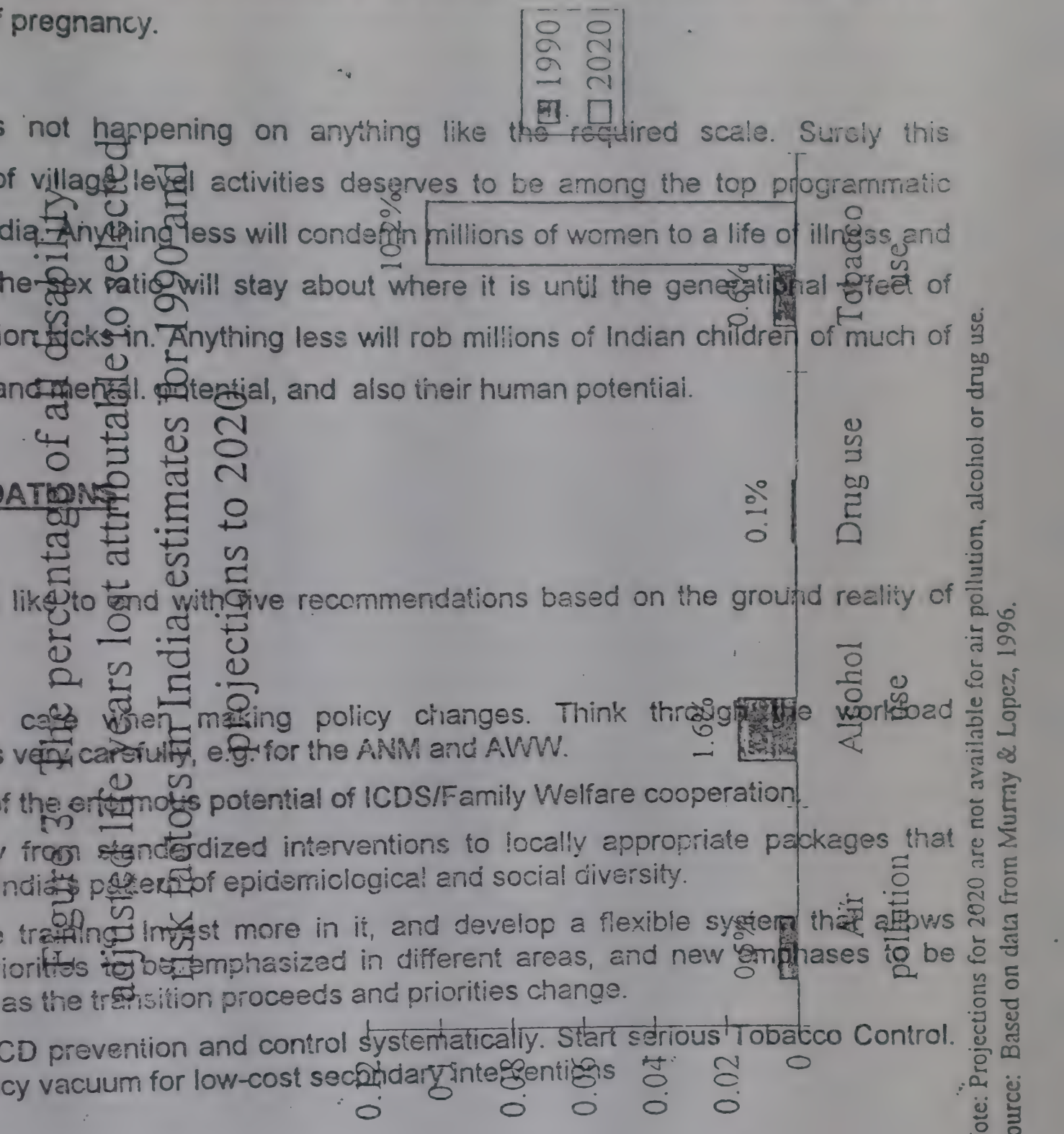
pregnancies be identified early enough to prevent or treat undernutrition, maternal complications, and LBW babies. Malnourished women need extra food at least from the fourth month of pregnancy.

But this not happening on anything like the required scale. Surely this convergence of village level activities deserves to be among the top programmatic priorities for India. Anything less will condemn millions of women to a life of illness and early death. The sex ratio will stay about where it is until the generational effect of female education kicks in. Anything less will rob millions of Indian children of much of their physical and mental potential, and also their human potential.

RECOMMENDATIONS

I would like to end with five recommendations based on the ground reality of India:

1. Move with care when making policy changes. Think through the workload implications very carefully, e.g. for the ANM and AWW.
2. Make use of the enormous potential of ICDS/Family Welfare cooperation.
3. Move away from standardized interventions to locally appropriate packages that meet India's pattern of epidemiological and social diversity.
4. Reorganize training. Invest more in it, and develop a flexible system that allows different priorities to be emphasized in different areas, and new emphases to be introduced as the transition proceeds and priorities change.
5. Address NCD prevention and control systematically. Start serious Tobacco Control. Fill the policy vacuum for low-cost secondary interventions



Note: Projections for 2020 are not available for air pollution, alcohol or drug use.
Source: Based on data from Murray & Lopez, 1996.

Figure 1. Causes of death in India: 1990 and projected for 2020 (percent of total deaths).

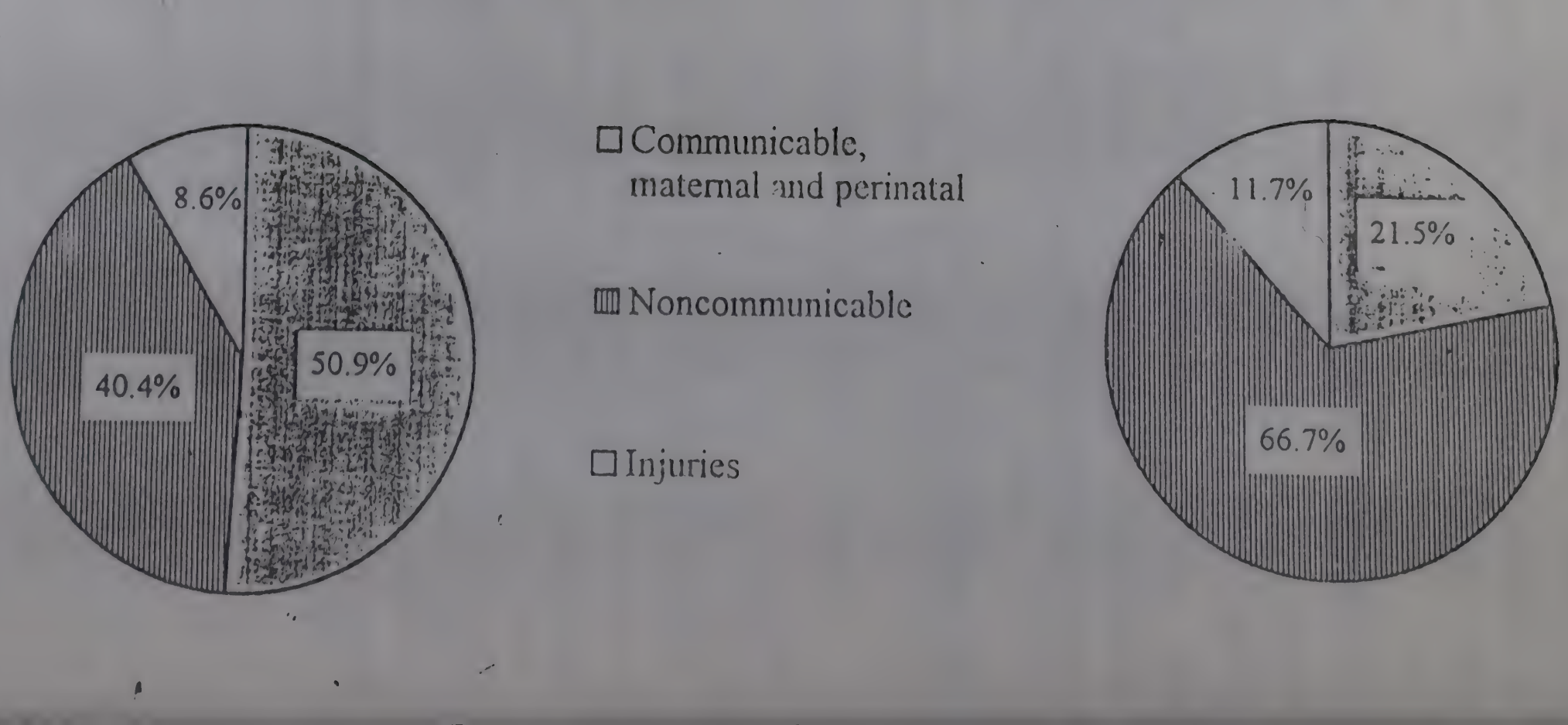


Figure 2. Causes of DALYs lost in India: 1990 and projected for 2020 (percent of total DALYs lost).

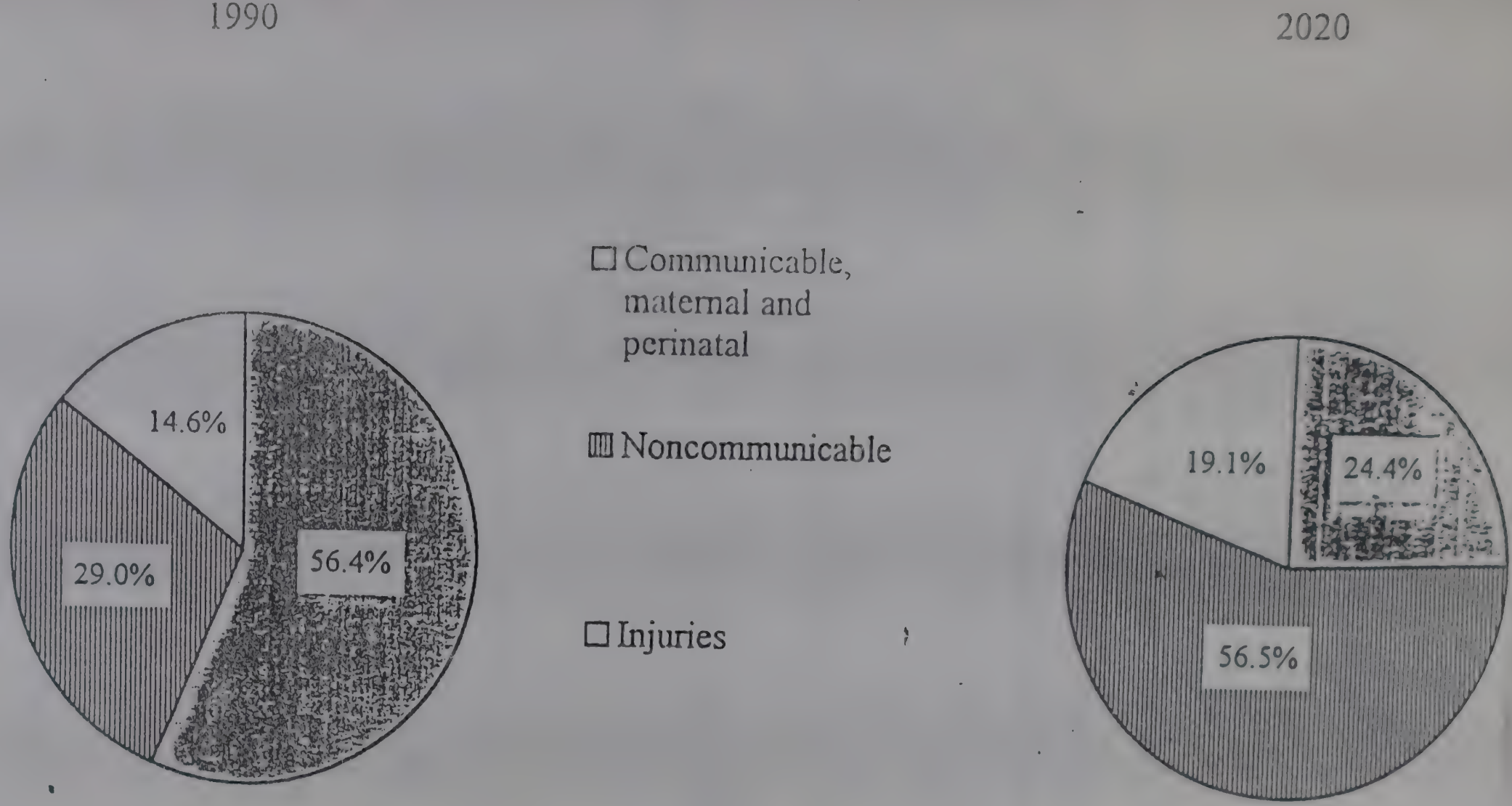
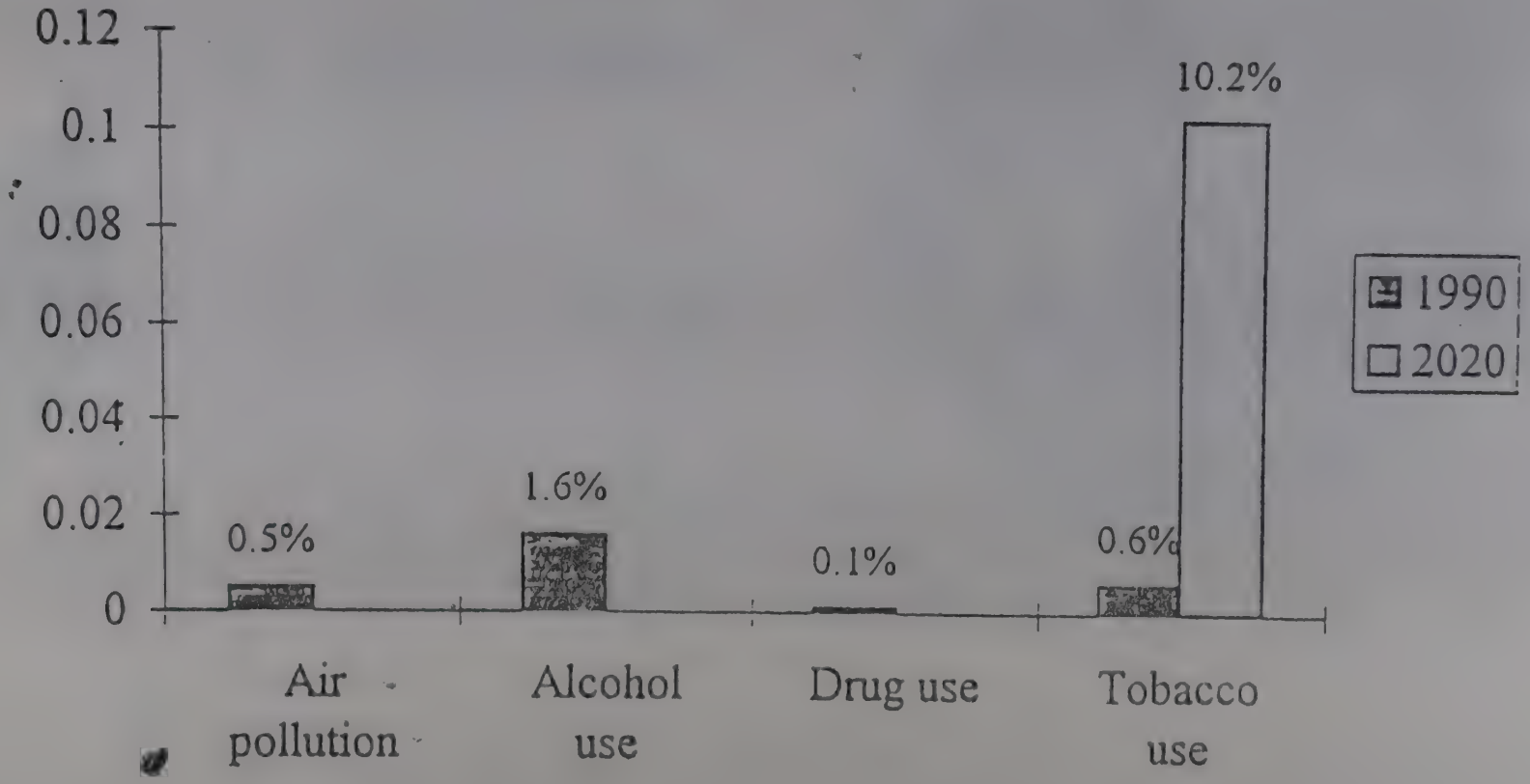


Figure 3. The percentage of all disability-adjusted life years lost attributable to selected risk factors in India, estimates for 1990 and projections to 2020



Note: Projections for 2020 are not available for air pollution, alcohol or drug use.
Source: Based on data from Murray & Lopez, 1996.

NONCOMMUNICABLE DISEASES : THE EMERGING EPIDEMICS

Dr K. Srinath Reddy
Professor of Cardiology,
Cardio-thoracic Centre,
All India Institute of Medical Sciences, New Delhi

Epidemics of non-communicable diseases (NCD) or chronic diseases of lifestyle (CDL) are presently occurring or accelerating in most developing countries. Even as infections and nutritional deficiencies are receding as leading contributors to death and disability, Cardiovascular diseases (CVD), cancers, diabetes, neuropsychiatric ailments and other chronic diseases are becoming major contributors to the burden of disease (1).

This transition is principally due to a combination of demographic and lifestyle changes which result from socio-economic development. Demographic transition is characterised by a decline in mortality, followed by a drop in fertility. During this transition, the age structure of the population changes from a pyramidal shape to a more columnar shape. As fertility declines, the population ages, which is then reflected in the profile of the causes of death. As industrialisation and urbanisation occur, decline occurs in the mortality attributable to infectious diseases and nutritional disorders. As more individuals survive to enter the middle ages, the years of exposure to the risk factors of chronic disease increase. Simultaneously, urbanisation and industrialisation are often accompanied by several undesirable lifestyle alterations in the form of a diet rich in saturated fat, salt and excess calories, decreased physical activity, addictions like tobacco and augmentation of psychosocial stress. Thus the dose and duration of risk factor exposure both increase, resulting in larger numbers manifesting lifestyle related diseases and their consequences. Health transition is characterised by a demographic transition in the age profile and an epidemiologic transition marked by the shift in the cause of death profile with the increasing dominance of NCD(2).

BURDEN OF DISEASE : PRESENT ESTIMATES

Even at the present stage of health transition, India contributes substantially to the global burden of NCD. In 1990, India accounted for 19% of all deaths, 16% of all NCD deaths and 17% of all CVD deaths in the world. CVD in India alone accounted for around 2.4 million deaths, in contrast to nearly 3.2 million deaths due to that cause in all the industrialised countries together (1).

While the present high burden of NCD deaths is itself an adequate reason for public health attention, a greater cause for concern is the early age of these deaths in India compared to the developed countries. More NCD deaths in South Asia occur in middle-age (35-69 years) than in industrialised countries, where they occur largely in old age (>70years). Table I provides a comparison between South Asia and established market economies (EME). In India, 52.2% of all CVD deaths in 1990 occurred before the age of 70 years, in contrast to 22.8% in the EME countries (1).

Table I : AGE PROFILE OF NCD DEATHS

Age at death* (yrs.)	South Asia	EME	Mean YLL+
< 35	20 %	3 %	60-65
35-69	45%	23%	20-25
≥ 70	35%	74%	5-10

* Neonatal exceptions at 1990 death rates
\+ YLL = years of Life Lost

Studies in migrant Indian communities, in several countries, have also indicated that men as well as women of Indian ethnicity have an excess risk of heart attacks, in comparison with all other ethnic groups (3). Studies in Indian migrants initially revealed a high prevalence of diabetes, central obesity and certain lipid abnormalities (collectively known as the 'metabolic syndrome').

Recent comparisons of rural and urban communities in India with Indian migrants and Europeans in UK reveal that, compared to rural Indians, urban and migrant Indians have an adverse CVD risk profile in terms of higher body weight, blood pressure and blood cholesterol (4). Thus a confluence of genetic and environmental risk factors appears to be responsible for the excess risk of heart attacks in urban and migrant Indians. However, the lower rates in rural Indians indicate that lifestyle related factors are the predominant determinants in such genetic-environmental interactions. This provides a cautionary caveat, as urbanisation occurs rapidly in India, that traditional protective elements of a rural lifestyle should not be abandoned.

The high prevalence of diabetes in urban and migrant Indians is also a cause for concern. Urban estimates of diabetes in adults aged over 35 years are in the range of 16-20%, while the corresponding rural estimates are around 4%. With such rates, it has been estimated that India has the largest number of diabetics in the world. As dietary habits and physical activity diseases with resultant obesity, diabetes will become an increasingly frequent contributor to NCD.

SOCIO-ECONOMIC IMPACT OF NCD AND EQUITY ISSUES :

Death or disability from NCD in the productive middle ages results in major economic burdens on the affected individuals, their families and society as a whole. The management of established NCD (diagnosis and therapy) is often technology intensive and expensive. Individual as well as societal resources are already being drained, at a disproportionately high level, by the tertiary care management of NCD, often drawing scarce resources away from the unfinished agenda of infectious disease and nutritional disorder control.

Though NCD epidemics usually originate in the upper socio-economic strata, they diffuse across the social spectrum, with the social gradient ultimately reversing and the poor becoming predominantly afflicted. This

historical experience of the developed countries, where the NCD epidemics matured over the past half-century, is likely to replicated in the developing countries in the coming half-century. There is recent evidence from some Indian studies that the social gradient for CVD has already begun to reverse in some population groups in India, especially in large urban settings. Tobacco consumption is also higher in rural as compared to urban populations and in the poor as compared to the rich. The future risk of tobacco related NCD is therefore likely to be higher in these groups. A comparison of per capita income profile and death rates Punjab, Maharashtra, Andhra Pradesh and Orissa in 1988 reveals that as per capita income profile progressively declines from Punjab to Orissa, the probability of death between the ages of 15-60 years progressively rises (19%,27%,34% and 38% respectively). NCD is a major contributor to deaths in this age group.

If the poor amongst countries and the poor within countries become increasingly vulnerable to the ravages of NCD, there will be large numbers who will be abandoned to the unaffordable pursuit of inaccessible tertiary care. Thus micro-economic, macro-economic and equity considerations demand programmes for the prevention and low-cost management of NCD.

PROJECTIONS :

Rising life expectancy with demographic shifts in the age profile, decline in the proportion of deaths attributable to pre-transitional diseases (infections, nutritional deficiencies) and lifestyle changes adversely affecting the risk factors of NCD are likely to accelerate the epidemiologic transition in India, with a further rise in the burden of post-transitional diseases (NCD/CDL). Based on demographic factors alone, major increases in CVD and Cancers have been projected to occur between 1985 and 2015 (Table II;Ref.5). Similar projections have been made by the recent estimates of the Global Burden of Disease Project of WHO for the transition during 1990-2020 (Table III). If the levels of NCD risk factors also rise in the population,

alongwith further industrialisation and urbanisation, the future proportional and absolute burdens of NCD will be even higher than projected on the basis of demographic modelling.

TABLE II : ESTIMATED AND PROJECTED MORTALITY RATES (PER 100 000),BY SEX, FOR MAJOR CAUSES OF DEATH, INDIA, 1995, 2000 AND 2015

	1985		2000		2015	
	M	F	M	F	M	F
All Causes	1158	1165	879	790	846	745
Infectious	478	476	215	239	152	175
Cancers	43	51	88	74	108	91
Circulatory	145	126	253	204	295	239
Pregnancy	0	22	0	12	0	10
Perinatal	168	132	60	48	40	30
Injury	85	65	82	28	84	29
Other	239	293	180	185	167	171

Adapted from ref.5.

Table III : BURDEN OF DISEASE IN 1990, AND PROJECTIONS TO 2020 (DALYs BY CAUSE, AS PERCENTAGE OF REGIONAL TOTAL - GLOBAL BURDEN OF DISEASE STUDY)

	1990			2020		
	I	II	III	I	II	III
World	43.9	40.9	15.1	20.1	59.7	20.1
SSA	65.9	18.8	15.4	39.8	31.9	28.3
IND	56.4	29.0	14.6	24.4	56.5	19.1
CHI	24.2	58.2	17.6	4.3	79.3	16.4
OAI	44.7	40.9	14.4	16.5	66.3	17.2
LAC	35.3	48.2	16.4	12.6	68.1	19.3
MEC	47.7	39.3	13.0	19.9	59.6	20.5
FSE	8.8	72.6	18.7	3.0	79.7	17.4
EME	7.1	81.0	11.9	5.2	84.7	10.1

Group I= Infectious, nutritional and perinatal diseases
Group II = Non-communicable diseases
Group III = Injuries

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STRATEGIES :

Traditionally, public health approaches to NCD control have been (a) a high risk strategy, targeting persons with high levels of risk factors and employing interventions to reduce them, usually with drugs and (b) a population strategy which attempts to reduce risk factor levels in the whole community usually through lifestyle related measures. The former provides higher benefits to individuals at maximum risk. However, since such individuals are a small segment of the society, there is no major impact on national morbidity or mortality on the country. The population approach aims at relatively modest reductions in the risk for each individual but the cumulative benefits to the community are large since there are many more persons in the mild or moderate range of risk factor elevation than there are in the highest range. The two strategies are not mutually exclusive but are synergistically complementary. However, population based and lifestyle linked strategies are likely to prevent the acquisition or augmentation of NCD risk factors in transitional societies, while avoiding the economic and biologic costs of pharmacological risk reduction strategies practised in the developed countries.

Simultaneously effective low-cost case-management strategies are required for persons who manifest disease. Such technologies are available but await widespread dissemination and application. For example, oral aspirin administration in cases of suspected heart attack saves as many lives as the intravenously administered clot dissolving drug streptokinase (Table IV). The community needs to be empowered, through information, to avail of such technologies.

Table IV : EFFECT OF TREATMENT OF 1000 PATIENTS WITH AMI

Drug	Premature deaths avoided	Cerebral haemorrages caused	Cost per life saved
Aspirin	23	0	Rs. 152
Streptokinase	25	2-3	Rs.1,23,560

At the population level, programmes for promotion of (a) a health promoting diet (calories appropriate to the level of physical activity; moderation in the intake of saturated fat, salt and refined sugar; high intake of fresh fruit and vegetables; fish in preference to red meat in non-vegetarian diets) and (b) adequate physical activity and regular exercise are required. These are likely to have benefits for a wide range of NCD, especially CVD, diabetes, hypertension and some cancers which are related to saturated fat intake.

Tobacco control is a major public health imperative which will provide the largest benefit, for NCD prevention. Tobacco-related cancers, CVD and chronic obstructive airway disease are amongst the diseases which can be effectively prevented if abstinence from tobacco and cessation of the tobacco habit are encouraged in the population. It has been estimated that of all the teenagers who are currently smoking, half will eventually die of tobacco related diseases (a quarter in the middle age and a quarter at an older age). For those who die of tobacco related illnesses in the middle age, the average loss of life-expectancy compared to non-smokers is 20-26 years. Tobacco and AIDS represent the most rapidly growing causes of death, the former being the foremost preventable cause of death in the modern world (6). Population based control strategies are clearly a high priority.

Such population strategies require both `bottom up' (community health education and empowerment) and `top down' (legislation and regulation) approaches. Whether it is food (production, pricing, labelling) or tobacco (production, sale, advertising) or physical activity (a conducive transport policy which favours urban cycle lanes and curbs vehicular transport as well as provides facilities for leisure time exercise in community playgrounds) – active health policy measures are required alongside public health education. An enlightened policy and an empowered community can together stall the advance of the emerging epidemics of NCD in India.

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ANNEXURE VIII

ISSUES AND OPTIONS FOR HEALTH FINANCE IN INDIA (SUMMARY NOTES)

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It is both an honour and a pleasure for me to have the opportunity to return to India and to join you for this Workshop in Goa. The Workshop's discussions have addressed strategic directions for the health sector in India. What I would like to bring to these discussions is some reflections on the experience of other countries and data from other countries that may help place issued in India into a wider context. The extent to which that external experience provides an useful input for thinking about policy options in India can only be judged by decision makers here.

I would like to divide my comments into four topics. The first concerns measurement of health system performance. The second and third topics present a simplified but strategic assessment of options for the medium to long-term for design of health delivery systems and of financial structure. Finally, implications for public finance of some of the financial options are touched upon.

Measuring of Health System Performance

Judging the adequacy of policy requires an assessment - quantitative or qualitative of system performance. Two main dimensions of performance concern, first, resource use of the health system, i.e. the burden it places on the rest of the economy, and second health outcomes. We have discussed resource use extensively during this Workshop; in the early 1990s. India was spending about 6% of GDP on health (narrowly defined to exclude expenditures in related areas such as food subsidies, water supply or sanitation). This level of expenditure is startlingly high typically countries at comparable income level spend only about 3.5% GDP on health. Naturally it

might make sense to spend more if this were being done in order to achieve better results. How, then, does India compare with other countries in terms of outcomes. Recently available data and analyses allow a relatively sharp answer to this question, at least with respect to the under-t mortality rate. India's under-5 mortality rate is now about 125, i.e. out of every 1000 live births, 125 will die before their fifth birthday. A comparison of India's performance relative to other countries controlling for income and education levels suggests that India's performance has been relatively poor. India India's under-5 mortality rate was 14% worse than would be expected (given its income and education level) in 1960; performance declined slightly by 1990 to 17% worse than predicted. A review of achievements/changes in performance over 5 years intervals between 1960 and 1990 reveals that, in the early 1960s for example, performance improved slightly but, in the early 1970s, it declined again. It is worth nothing that, in contrast to the situation with health, performance in reducing fertility has been quite good; although in 1960, India's TFR was about what would be expected, by 1990 it was 26% better. There were steady improvements in performance over this entire period with the exception of a slight setback in 1980-85.

These measures of India's relative performance on both resource use and on health outcomes raise disturbing questions about policy. Perhaps, for some reason, the siutation is just very different in India; but, plausibly, better policies could achieve some combination of reduced expenditures and better relative health outcomes.

Options for Delivery Systems

More complex systems evolved in response to problems with earlier generation ones. Very simple first generation structures which characterise perhaps 75% of the Indian system today-lacked risk-sharing mechanisms; and demand for more efficient coverage of risk led to various second generation systems that embody substantial prepayment of clinical expenses to pool risks. Countries of the OECD prepay between 80% of health

expenses (U.S.) and 95% (U.K.). Rising income in India will also lead to demand for prepayment. The Central Policy choice is whether to meet this demand through public finance or (publicly mandated finance) or through private voluntary insurance. In terms of health outcomes and, even more dramatically in terms of costs, the international experience suggests that India will be much worse of, if it follows the U.S. rather than the European path forward second generation systems.

Options for Finance

One Centrally important question here concerns what to finance. The large variations we see in the country performance on health outcomes results substantially, I believe, from how well countries choose off the large available menu of health outcomes. Increasingly, we have the cost-effectiveness information to inform those choices.

How the system is financed powerfully influences incentives throughout the system. Fee for service payment of providers, for example, has created in many countries unnecessary cost escalation along with excessive and inappropriate care. (China, India and the U.S. all provide many examples of this). Increasingly strong evidence suggests that a substantial public sector role in financing health systems creates an incentive environment for cost containment and for better intervention selection that results in improved performance on health outcomes. In this context, it is important to note that not only does India today have exceptionally high health expenditures, but it also has one of the world's lowest levels of public involvement in health finance.

Let us consider a very personal and impressionistic projection of two alternative future for the broad patterns of health finance in India. The first summarizes the situation of the early 1990s. Both projections for the year 2010 suggest an increase in the fraction of India's GDP likely to be spent on health: International experience consistently suggest that this percentage will

rise both as incomes grow and as populations age. The second assumes little charges in India's policies towards health finance, i.e. that health finance will remain overwhelmingly private. Again, experience from abroad (U.S., Korea, Chile, China) points to the likelihood that expenditure increases will be amplified in a policy regime of private finance. At the same time growth will be limited and improvements in health outcomes will be achieved more slowly. The Third an alternative scenario involving a transition to a more substantial role for the public sector in health finance (not necessarily in service delivery) obviously these projections for 2010 are highly speculative; yet they do portray, I would argue, a qualitatively plausible vision of the consequences of alternative broad directions for financial policy.

Implications for Public Finances

The Scenario involving a policy change toward more public finance would face the major hurdle associated with the currently very pressed State of the Government's budget. Current deficits are running at a very high 6% of GDP; proposals for increased spending, however justified on grounds of macro-efficiency, face a short term finance constraint. Yet the reforms of public finance required to put India into an East Asian growth trajectory would inevitably involve major reductions in government subsides to agriculture, state-owned enterprises and other area; likewise it would involve reforms on the revenue generation side. Reforms of labour laws to liberalize labour makrets would likewise assist finance by facilitating the growth of social insurance.

ANNEXURE IX

REFLECTIONS ON THE WORKSHOP

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Challenges

In comparison to manYcountries, India spends a greater proportion of national income on health but, in terms of health outcomes, is not achieving the expected return on this investment. There is thus a compelling argument for a shift from private out-of-pocket expenditure to public investment, which will require fundamental structural changes in the way the sector is financed, organised and managed. However, while there is a need to formulate a coherent strategy for reform, legislators and officials are hard pressed to cope with the immediate demands placed on them by parliament, the press and the public. In the absence of the kind of major crisis or political change that has provoked reform in other parts of the world, there is a danger that the urgent will continue to displace the important.

It is also apparent that the spectrum of disease and the causes of ill-health in India are changing and will continue to do so. There will be inevitable shift from communicable to non-communicable disease, but even within these broad categories, priorities will continue to evolve. Challenges present themselves in different ways. In the case of AIDS, the difficulty is one of acknowledging the problems, in the face of public and political reluctance to do so. With the diseases attributable to tobacco, potentially effective solutions lie outside the direct control of the health sector. More fundamentally, there is a need for effective processes for deciding on priorities and for arbitrating between competing claims for scarce resources. In the absence of mechanisms for deciding on priorities at national and state level, there is a danger that choices and made either by the availability of

external funds or are influenced by the professional or provider groups with the loudest voice.

Key themes and issues

Resource allocation

The need to reduce disparities both between and within states and districts is clearly a major concern. Discussion centred on the relative merits of population-sized norms versus burden of disease methods. Whilst most people recognised the limitations of the former, it is probably unhelpful to pose these approaches as mutually exclusive. Both have their drawbacks. Epidemiological methods, combined with cost-effectiveness studies can help in defining the most appropriate range of services that should be publicly funded. However, burden of disease studies do not in themselves guarantee that distribution issues will be addressed. Also the central definition of essential packages, can limit the scope for the local adaptation required in a decentralised system. On the other side of the coin, population-size norms can be equally rigid and in some circumstances wasteful. Resource allocation needs to be sensitive to a variety of factors. States and districts need to make plans with a clear sense of the toal quantum of resources available. Burden of disease studies are needed to refine choices, but should not constrain them.

Autonomy: Decentralising management

There is a growing consensus that greater managerial autonomy is essential. Decentralisation can take many forms and discussion at the meeting reveals that it will be necessary to think about several sets of relationships in this regard. between centre ad states; between states and public sector corporations; and between state and local government. In addition, there is a need to think about decentralising the management of hospitals and, in the absence of local government structures, to explore the potential of district boards. Central to all these initiatives, there is a need to

review the nature of the controls exerted by one level on the next- moving from traditional bureaucratic means to monitoring performance.

Second, there is a need for managers - and a shift from administration of a centrally controlled system to one that is actively managed. At present management capacity is limited and will require a sustained process of management development (and not just training). One of the greatest challenges will be to establish systems and people capable of managing professionals. As the Minister said in his address; the providers have been dominant for too long.

Changing sources of health finance

The introduction of user charges has been central to reform at state level. The debate is now just beginning as to the potential income from this source; about mechanisms for ensuring that fees to not limit access; to the uses of internally generated funds; and the extent to which this income should be used to provide a financial incentive to providers. These debates would appear to have a long way to run, but it would seem desirable that rather than a single national policy, decisions need to take account of local circumstances state by state. There is also a growing interest in different forms of health insurance. Whilst most recognise the dangers inherent in expanding the private insurance market, there remains a great deal of thinking to do on the subject of social insurance. To what extent will an expansion of social insurance in the formal sector lead to a two-tier systems for the insured and uninsured? Given the need to develop stronger purchasers as a means of controlling the cost and quality of private care, is an institutionalised two-tier system the inevitable price that will have to be paid?

Relationships with the private sector

Much is said about the need to regulate the private sector. From the discussions it appears that the focus of thinking to date has focused on

individual rights - through legislation such as the Consumer Protection Act. The difficulty of enforcing legislation in the Indian context is widely acknowledged and thus a broader range of strategies is needed. A wide range of ad-hoc approaches are already being tried. There is a need to synthesise this experience. Much public subsidy to the private sector has failed to produce the expected returns. Experience here needs to be reviewed in order not to repeat the mistakes of the past. Arrangements whereby public sector organisations purchase services from the private and voluntary sector offer the opportunity to exert a greater degree of control over cost and quality. For this to be possible requires that savings be made in the public sector and that the public organisations have the capacity to define needs, prepare adequate contracts and monitor performance of their contractors. Experience round the world suggests that this will require a sustained investment in capacity building.

Conclusions

The Goa meeting demonstrated beyond doubt that there is a growing recognition of the problems facing the health sector. Meetings such as this provide a rare and valuable opportunity to step back from day-to-day pressures and allow senior officials the time to think about future strategy. The issues are complex and there is an evident need for a common vocabulary for discussing structural and systemic change. Meetings such as this can help in developing a coherent discourse about reform. Whilst the workshop identified some broad areas which are likely to become the focus of change in the next few years, there is work to be done or defining issues more precisely and analysing the options facing central and state governments. Capacity to carry out high quality policy analysis is urgently required. Whilst much of the detailed work can be carried out by institutions outside government, the national and state ministries, need their own units for defining strategic options and commissioning studies. Furthermore, senior officials need to seek opportunities to discuss problems and experience with counterparts in other parts of the world.